Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

State of California **Department of Health Services**

Submission Date:	

CMS Receipt Date *(CMS Use)***:**	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
This application is requesting the renewal of the Nursing Facility Level A and B (NF A/B) Waiver, Control Number 0139.90 and to combine the Nursing Facility Subacute (NF SA) Waiver, Control Number 0384.01 and the In-Home Medical Care (IHMC) Waiver, Control Number 0348.90, with the NF A/B Waiver, and to change the name of the waiver to the Home and Community-Based Services (HCBS) Nursing Facility/Acute Hospital (NF/AH) Waiver. The Department will submit a letter to CMS within 30 days of the approval of the combined waiver, requesting termination of the NF SA and IHMC Waivers to be effective 90 days from approval date of the HCBS NF/AH Wavier approval date.

Application for a §1915(c) Home and Community-Based Services Waiver

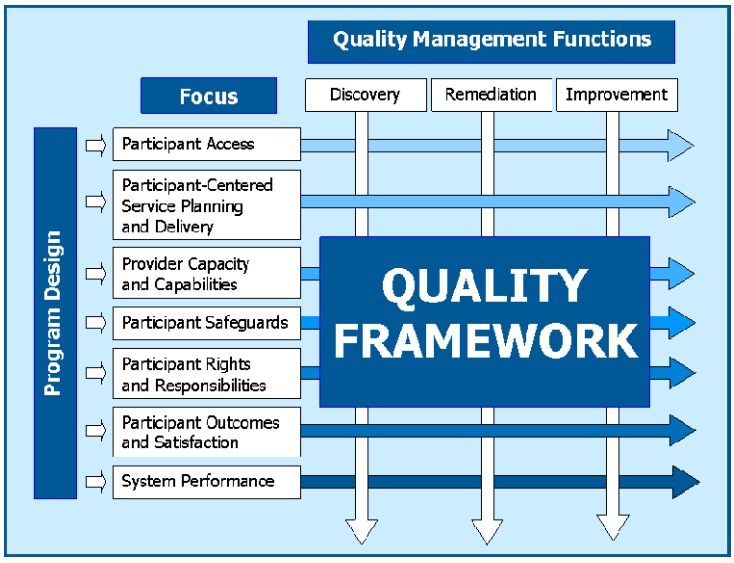
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state, and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*



State:	California
Effective Date:	January 1, 2007

Application: 1

- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*

The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

A. The **State** of **California** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): **Home and Community-Based Services (HCBS) Nursing Facility/Acute Hospital (NF/AH) Waiver**

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #**		
	CMS-Assigned Waiver Number (*CMS Use*):		
	Attachment #1 contains the transition plan to the new waiver.		
X	**Renewal (5 Years) of Waiver #**	**0139.90**	
○	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date:	**January 1, 2007**
E.2 Approved Effective Date *(CMS Use):*	

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan :

X	Hospital *(select applicable level of care)*	
	X	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
		Individuals must meet the criteria for hospital level of care (LOC) for 90 consecutive days or greater and the medical care criteria as described in Appendix B-1.
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	X	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
		A, B, and Subacute LOC.
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates :			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
X	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Home and Community-Based Services (HCBS) Nursing Facility/Acute Hospital (NF/AH) Waiver is to provide Medi-Cal beneficiaries with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute, skilled or intermediate nursing facility (NF) LOC with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of institutionalization.

The goals of the waiver are to (1) facilitate a safe and timely transition of Medi-Cal eligible beneficiaries from a medical facility to his/her home and community utilizing NF/AH Waiver services; and (2) offer Medi-Cal eligible beneficiaries, who reside in the community but are at risk of being institutionalized within the next 30-days, the option of utilizing NF/AH Waiver services to develop a home program that will safely meet his/her medical care needs.

The waiver's objectives are to:

- Increase the enrollment of the intermediate and skilled NF LOC by 500 slots in the first two years of this waiver of which, 250 slots will be reserved to transition Medi-Cal eligible beneficiaries from an intermediate or skilled nursing facility to his/her home and community;
- Issue a Notice of Action (NOA) within 90 days from the approval date of the NF/AH Waiver to all participants of the NF SA, 0384.01 and IHMC, 0348.90 waivers who continue to meet the NF SA or IHMC waiver's criteria informing him/her that he/she will be terminated from his/her assigned waiver and enrolled in the NF/AH Waiver without interruption or disruption to his/her current HCBS home program;
- Provide the participants and his/her providers a seamless transition among the LOC within this waiver, as appropriate, based on his/her medical care needs; and,
- Establish and maintain overall cost neutrality of this waiver through the establishment of individual institutional cost limits assisted by the use of the In-Home Operations (IHO) Menu of Health Services (MOHS). The MOHS documents the costs of the participant's selected NF/AH Waiver and State Plan services, so as to not exceed the Medi-Cal institutional cost at the participant's assessed LOC and facility type.

The California Department of Health Services (CDHS), HCBS Branch, IHO Section,

is responsible for the implementation and monitoring of the HCBS NF A/B Waiver #0139.90. Organizationally, IHO has two regional offices. The northern and southern California regional offices are responsible for conducting initial waiver LOC evaluations, LOC reevaluations, and ongoing administrative case management activities. Waiver participants must have a current Plan of Treatment (POT) signed by the participant and/or legal representative, the participant's primary care physician and all HCBS Waiver providers that describes all the participant's care services, frequency and providers of the identified services that ensure his/her health and safety in a home and community setting. Waiver services are delivered through traditional Medi-Cal HCBS Waiver providers, such as home health agencies, durable medical equipment companies, individual nurse providers, licensed clinical social workers, marriage and family therapists, personal care agencies, and individual personal care service providers. The waiver participant has the option of selecting the provider of waiver services that are appropriate to his/her care needs.

IHO's capability to add an additional 500 slots and authorize the services described in this waiver to the extent these services are new and not previously provided through the NF A/B, NF SA or IHMC Waivers is subject to the approval by the California Department of Finance and authorization of the State Legislature of appropriations to support an increase in waiver expenditures. The following are the proposed new services, as described in Appendix C:

- Habilitation Services
- Community Transition Services

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

○	The waiver provides for participant direction of services. *Appendix E is required*.
X	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

X	Yes
○	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
X	**No**

If yes, specify the waiver of statewideness that is requested :

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are:(1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer

does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

CDHS will submit the draft waiver to the Olmstead Advisory Committee for public comments prior to approval from CMS. The waiver will be posted for public access on the Medi-Cal website at http://www.dhs.ca.gov/mcs/mcod/ihos/default.html.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Barbara
Last Name	Lemus
Title:	Chief, Waiver Analysis Section
Agency:	California Department of Health Services
Address 1:	MS 4615, P.O. Box 942732
Address 2:	1501 Capitol Avenue
City	Sacramento
State	CA
Zip Code	94234-7320
Telephone:	916-552-9633
E-mail	Blemus@dhs.ca.gov
Fax Number	916-552-9660

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	**Date:**	

State Medicaid Director or Designee

First Name:	Stan
Last Name	Rosenstein
Title:	Deputy Director, Medical Care Services
Agency:	California Department of Health Services
Address 1:	MS 4000, PO Box 942732
Address 2:	1501 Capitol Ave
City	Sacramento
State	CA
Zip Code	94234-7320
Telephone:	916-440-7800
E-mail	SRosenst@dhs.ca.gov
Fax Number	916-440-7805

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Medi-Cal Operations Division (MCOD) IHO is requesting the NF A/B Waiver, 0139.90 to include the NF SA and acute hospital LOC and to be renamed as the Home and Community-Based Services Nursing Facility and Acute Hospital (HCBS NF/AH) Waiver. Upon CMS approval of the renewed waiver application, IHO will transition the participants who continue to meet the criteria for the NF SA, 0384.01 and IHMC, 0348.90 Waivers to the renewed waiver. As all three waivers essentially provide the same services and utilize the same provider types with minor exceptions, participants may be transferred to the renewed waiver without any disruption to his/her current services.

To transition waiver participants from the NF SA and IHMC Waivers into the renewed NF/AH Waiver, IHO will evaluate each participant using the criteria that is outlined in this waiver. The evaluations will be conducted during the six months prior to the effective renewal date of this waiver, January 1, 2007. Continued Medi-Cal eligibility shall also be ascertained for the individual participant. If it is determined that a participant of the NF SA or IHMC Waiver is ineligible for transition to the renewed waiver, HCBS IHO staff will assist in providing the participant with information on other available resources within the community, including information on how to access other available HCBS waivers and/or State plan services.

NF SA and IHMC Waiver participants and/or his/her legal representative will receive written notice of his/her eligibility to transition to the renewed waiver within 90 days after the approval date of this waiver and request his/her acceptance or declination of the transition to this waiver. Participants who decline the transition will be assisted in the same manner as those who are ineligible for transition to the renewed waiver.

The Department will submit within 30 days of the approval of the HCBS NF/AH Waiver a letter to CMS requesting termination of the NF SA and IHMC Waivers to be effective 90 days from the combined waiver's approval date.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

X	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):		
	X	The Medical Assistance Unit *(name of unit)*:	Medical Care Services, Medi-Cal Operations Division, Home and Community-Based Services Branch
	○	Another division/unit within the State Medicaid agency that is separate from the Medical	
		Assistance Unit (name of division/unit)	
○	The waiver is operated by		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*		

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

○	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

X	**No.** Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
X	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed :

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	X	☐	☐	☐
Assist individuals in waiver enrollment	X	☐	☐	☐
Manage waiver enrollment against approved limits	X	☐	☐	☐
Monitor waiver expenditures against approved levels	X	☐	☐	☐
Conduct level of care evaluation activities	X	☐	☐	☐
Review participant service plans to ensure that waiver requirements are met	X	☐	☐	☐
Perform prior authorization of waiver services	X	☐	☐	☐
Conduct utilization management functions	X	☐	☐	☐
Recruit providers	X	☐	☐	☐
Execute the Medicaid provider agreement	X	☐	☐	☐
Determine waiver payment amounts or rates	X	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	X	☐	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
X	**Aged or Disabled, or Both**			
X	Aged (age 65 and older)			X
X	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
X	Medically Fragile			X
X	Technology Dependent			X
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Participants served under this Home and Community-Based (HCBS) Nursing Facility/Acute Hospital (NF/AH) Waiver will need to have an identified support network system available to them in the event the HCBS provider of direct care services is not able to provide the total number of hours approved and authorized by Medi-Cal Operation Division (MCOD), In-Home Operations (IHO). The support network system may consist of care providers, community-based organizations, family members, primary physicians, home health agencies, a member of the participant's medical team, licensed foster parent or any other individual that is part of the participant's circle of support. The participants' circle of support may consist of family members, legal representative, and any other individual named by the participant. Members of the support network providing direct care services in the absence of the authorized HCBS waiver provider will be identified on the Plan of Treatment (POT)

Acute Hospital Level of Care (LOC)

This waiver will serve Medi-Cal beneficiaries, who would, in the absence of this waiver, and as a matter of medical necessity, pursuant to Welfare and Institutions (W&I) Code, Section 14059, meet criteria for care in a hospital for at least 90 consecutive days. Participants to be served under this waiver would have the following conditions: traumatic or acquired neuromuscular impairment and/or a complex debilitating illness. The participant would have substantial skilled nursing medical care needs over a 24-hour period and would require the presence of a licensed nurse to provide continuous evaluation and administration of three or more of the skilled nursing interventions listed below and prescribed in the POT:

1. Dependent on life-sustaining medical technology for more than 50% of the day.
2. Evaluation for and administration of supplemental oxygen as needed, and a need for suctioning at least three times every eight (8) hours.
3. Total Parenteral Nutrition (TPN) a minimum of three (3) times a week.
4. Tube feeding (nasogastric or gastrostomy) continuously or intermittently three (3) or more times a day.
5. Continuous IV therapy involving the administration of therapeutic agents or IV therapy necessary for hydration, or daily IV drug administration via a peripheral and/or central line without continuous infusion.
6. Two (2) or more medical treatments every shift with a minimum of six (6) treatments per 24-hour period (i.e., respiratory treatment with prescribed medications, stage 3 and 4 wound care, intermittent catheterization, ostomy

care, tracheostomy care).

7. Need for evaluation by a licensed nurse and the administration of *Pro Re Nata* (PRN) medications at minimum of every eight (8) hours per day.

All requests for acute hospital LOC waiver services shall meet the criteria as described in this waiver in addition to the criteria set forth in Title 22, California of Regulations (CCR), Sections 51344 and 51173.1.

For each reevaluation the participant must continue to meet the criteria as described in the above cited CCR and W&I Codes, in addition to the other criteria outlined in this waiver application.

Nursing Facility

This waiver will serve Medi-Cal beneficiaries who would, in the absence of this waiver, and as a matter of medical necessity, pursuant to W&I Code, Section 14059, otherwise require care in an inpatient nursing facility (NF) providing the following types of care:

1. NF Level A services pursuant to Title 22, CCR, sections 51120 and 51334.
2. NF Level B services pursuant to Title 22, CCR, sections 51124 and 51335.
3. NF Sub acute services, pursuant to Title 22, CCR, Section 51124.5, or
4. NF Pediatric Subacute services, pursuant to Title 22, CCR, Section 51125.6.

For each reevaluation the participant must continue to meet the criteria as described in the above cited CCR and W&I Codes, in addition to those additional criteria outlined in this waiver application.

Other NF LOC criteria are:

- All waiver participants must meet the criteria for care in a nursing facility for at least 180 consecutive days;
- The NF Level B includes three (3) facility types for Medi-Cal reimbursement. The participant must meet the criteria for one of the three facilities listed below, in addition to the other criteria outlined in this waiver:
  1. Skilled NF, described in Title 22, CCR, sections 51124 and 51335, and the waiver participant is 21 years of age and older;
  2. Pediatric NF, described in Title 22, CCR, sections 51124 and 51335, and the waiver participant is under the age of 21; and,
  3. Distinct Part NF, participant who meets the care needs described in W&I Code 14091.21 (b)(1)(F) and Title 22, CCR, sections 51124 and 51335.
- All requests for NF waiver services shall meet the criteria set forth in Title 22, CCR, Section 51344, et seq.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

X	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit:

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

○	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
	○ _____ %, a level higher than 100% of the institutional average
	○ Other : _____
X	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.
	_____
	The cost limit specified by the State is *(select one)*:
	○ The following dollar amount: $ _____ [redacted]
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:

		○	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.		
	○	The following percentage that is less than 100% of the institutional average:			%
	○	Other – *Specify:*			

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The CDHS/IHO NE utilizes the following procedures to determine in advance of waiver enrollment that the individual's health and welfare can be assured within the institutional cost limit:

1) The CDHS/IHO NE schedules a face-to-face intake visit with the waiver participant and/or legal representative and completes an initial Level of Care Evaluation for NF/AH waiver services. During the evaluation the CDHS/IHO NE documents the State Plan services the participant is currently receiving. The information from the initial LOC evaluation is then documented on the Intake Medical Summary (IMS) form along with medical justification to support the LOC, and facility type determination.
2) Upon determination of the participant's LOC the CDHS/IHO NE provides information to the participant and/or his/her legal representative(s), and/or circle of support on the services available through the HCBS NF/AH Waiver, the institutional cost limit for the participant's LOC, the facility type, and the waiver's institutional cost neutrality requirements. The CDHS/IHO NE works with the participant and/or his/her legal representative and/or circle of support, the participant's physician, and the HCBS NF/AH Waiver case manager in identifying the State Plan and HCBS NF/AH Waiver services that meet the participant's care needs and do not exceed the participant's institutional cost limits.

   The costs of the identified State Plan and Waiver services are documented in the Menu of Health Services (MOHS) worksheet and provided to the participant and/or his/her legal representative prior to enrolling in the HCBS NF/AH Waiver. The MOHS is a planning instrument used by the participant and/or his/her legal representative, circle of support, HCBS NF/AH Waiver

Case Manager, and the CHDS/IHO NE to develop of a home care program. The MOHS summarizes all the waiver services and provider types available to the participant. The MOHS enables the participant and/or his/her legal representative(s) and/or his/her circle of support to select a combination of waiver services best suited to meet his/her medical care needs and ensure his/her health and safety.

3) If the cost of the State Plan and Waiver services selected by the participant and/or his/her legal representative exceed the participant's institutional cost limit and the participant and/or his/her legal representative does not want to make any changes to the selected services, IHO will issue a Notice of Action denying enrollment in the HCBS NF/AH Waiver due to not meeting the waiver's cost neutrality requirement.

CDHS has established Factor G for Waiver Year 1 as described in Appendix B-2 and listed in Appendix J-1 as the institutional cost limit for each facility type. Increases in the NF/AH Waiver institutional cost limit will require the approval by the California Department of Finance, authorization of the State Legislature of appropriations to support an increase in waiver expenditures and the CMS approval to amend the NF/AH Waiver to increase the institutional cost limit.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant :

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:

X	Other safeguard(s) :
	When there is a change in the participant's condition or circumstances post entrance to the waiver that requires the provision of services in an amount that exceeds the institutional cost limit, the following safeguards have been established to avoid an adverse impact on the participant: 1) If the cost of the selected State Plan and Waiver services exceed the participant's institutional cost limit, the HCBS NF/AH NE will work with the participant and/or his/her legal representative and/or circle of support and HCBS NF/AH Waiver Case Manager in identifying services that will meet the participants health and safety needs and not exceed the participant's institutional cost limit. 2) The participant is reevaluated to determine if he/she meets the criteria for another LOC and/or facility type described in this waiver. Upon determination of a change in the LOC and facility type, the appropriate institutional cost limit will be used in the MOHS to determine if the cost of the participant's services to ensure his/her health and safety meet the waiver's cost neutrality requirement. 3) If the cost of the participant's services exceed his/her institutional cost limit and the participant does not meet the criteria for another LOC and facility type within this waiver, the CDHS/IHO NE will contact the participant and/or his/her legal representative, the participant's HCBS NF/AH Waiver Case Manager, and the participant's physician to discuss alternative options, which may include transfer to another California HCBS Waiver or admission into a facility.

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a
Unduplicated Number of Participants

Waiver Year	Nursing Facility A/B LOC	Nursing Facility Subacute LOC	Hospital LOC	Total
Year 1	1390	905	300	**2595**
Year 2	1500	955	300	**2755**
Year 3	1610	1005	300	**2915**
Year 4	1720	1055	300	**3075**
Year 5	1830	1105	300	**3235**

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
X	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	**2595**
Year 2	**2755**
Year 3	**2915**
Year 4 (renewal only)	**3075**
Year 5 (renewal only)	**3235**

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○	**Not applicable.** The state does not reserve capacity.
X	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	Reserved capacity is for individual inpatients in a licensed NF under W&I Code 14132.99 at the B LOC transitioning to a home or home-like setting in the community as required by Senate Bill 643, Chapter 551, Statutes of 2005. Annual enrollment in the NF/AH Waiver of individuals who are inpatient and transitioning to the community may exceed reserved capacity. If this occurs, they are enrolled as described at item B-3-f, based on the order of receipt of the completed HCBS Waiver Questionnaire.
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose: Community Transition Capacity Reserved	Purpose: Capacity Reserved
Year 1	50	
Year 2	50	
Year 3	50	
Year 4	50	
Year 5	50	

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

X	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

X	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Each year beginning January 1 2007, the maximum unduplicated count of participants enrolled in the NF/AH Waiver is will increase up to capacity as described in Appendix B:3:1.. Unused waiver capacity is referred to as available "waiver slots" for purposes of establishing and maintaining a waiting list for enrollment. Enrollment into the NF/AH Waiver is limited to the maximum number of waiver slots authorized for each waiver year. When there are no available waiver slots during the waiver year, the Department, through IHO, will establish and maintain a waiting list of individuals eligible for potential enrollment in the NF/AH Waiver. Waiver slots that become available due to the death of a participant will be filled with a new participant from the appropriate waiting list.

An individual requesting NF/AH Waiver services must completed HCBS Waiver Questionnaire to IHO. The CDHS/IHO NE will identify the applicant's LOC based on the information provided. If there are no waiver slots available, potential waiver participants who meet the waiver's LOC criteria, will be placed on the waiting list. IHO will send a letter confirming receipt of the completed HCBS Waiver Questionnaire, indicating the effective date of placement on the NF/AH Waiver waiting list.

Available waiver slots will be assigned to NF/AH Waiver eligible individuals who are on the waiting list in the following order:

1. Individuals residing in a health care facility at the time of submission of the HCBS Questionnaire to IHO,
2. Individuals residing in the community at the time of submission of the HCBS Questionnaire.

Multiple completed HCBS Waiver Questionnaires received on the same day shall be prioritized numerically based upon the applicant's birth date, 1 through 31, without consideration to the month or year. It is the responsibility of the individual

on the NF/AH Waiver waiting list to notify IHO in writing of any change in circumstances that may change the individual's priority enrollment or wait list priority, such as changes in health care status.

Open enrollment slots are filled on a rotating basis from the above mentioned waiting list, offering the first opportunity for waiver enrollment to an individual at the top of the list of individuals residing in a health care facility wishing to transition to the community. The second opportunity for enrollment will be offered to the individual at the top of the list of individuals residing in the community. The third opportunity will be offered to the individual at the top of the list of individuals residing in a health care facility, and so forth. If an individual is unable to accept or declines waiver enrollment, the open waiver slot will be offered to the individual at the top rank in the order of rotation.

Priority enrollment into the NF/AH Waiver is given to individuals who meet all the following criteria:

1. The participant must be a current Medi-Cal beneficiary who will turn 21 years of age during the current waiver year and must have been receiving or have been authorized for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental private duty nursing services for at least six months prior to his/her 21st birthday;
2. The participant must submit a completed HCBS Waiver Questionnaire; and
3. The participant must be eligible for placement into the NF/AH Waiver.

IHO may reserve waiver slots for priority enrollment beneficiaries to prevent interruption of existing home and community-based services.

An individual who is notified of an available waiver slot on the NF/AH Waiver must schedule a face-to-face evaluation with IHO within 60 days of notification. An individual who has not advised IHO of his/her intention to elect to receive waiver services or fails to schedule a face-to-face evaluation within 60 days or who declines waiver services shall be removed from the NF/AH Waiver waiting list and sent a Notice of Action (NOA) terminating the availability of waiver services.

To assist in the transition to home and community-based services, an individual who is an inpatient in a licensed NF or acute care hospital who is offered a waiver slot is encouraged to enroll into the NF/AH Waiver as soon as possible and, if necessary, utilize waiver Transitional Case Management (TCM) services, described in the waiver, to coordinate services such as housing, equipment, supplies, or transportation before discharge to the community. TCM services may begin up to 180 days prior to discharge from an institution.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. Waiver Years Subject to Phase-In/Phase-Out Schedule:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
		Waiver Year:	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

X	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
X	Low income families with children as provided in §1931 of the Act		
X	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
X	Optional State supplement recipients		
X	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	X	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
X	Medically needy		

X	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:
	All other mandatory and optional eligibility groups under the Medi-Cal State Plan are included.

Special home and community-based waiver group under 42 CFR §435.217)

Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.

X	All individuals in the special home and community-based waiver group under 42 CFR §435.217				
○	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 :				
	☐	A special income level equal to (select one):			
		○	300% of the SSI Federal Benefit Rate (FBR)		
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)	
		○	$	which is lower than 300%	
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
	☐	Aged and disabled individuals who have income at: *(select one)*			
		○	100% of FPL		
		○	%	of FPL, which is lower than 100%	
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):	
	X	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1 Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):		
○	The following standard included under the State plan *(select one)*	
	○	SSI standard
	○	Optional State supplement standard

	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
	○	300% of the SSI Federal Benefit Rate (FBR)		
	○	%	of the FBR, which is less than 300%	
	○	$	which is less than 300%.	
	○	%	of the Federal poverty level	
	○	Other :		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			

ii. <u>Allowance for the spouse only</u> (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
X	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the
	higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.		
○	The amount is determined using the following formula:		
○	Other :		
X	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

- ○ The State does not establish reasonable limits.
- ○ The State establishes the following reasonable limits :

c-1 Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300% of the FBR
  - ○ % of the Federal poverty level
  - ○ Other :
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. <u>Allowance for the spouse only</u> (*select one*):

- ○ The following standard under 42 CFR §435.121

○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		
iii. <u>Allowance for the family</u> *(select one)*			
○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher
	of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.		
○	The amount is determined using the following formula:		
○	Other :		
○	Not applicable (see instructions)		
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:			
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	The State does not establish reasonable limits.		
○	The State establishes the following reasonable limits :		

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2 Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

X	The following standard included under the State plan *(select one)*				
	○	SSI standard			
	○	Optional State supplement standard			
	○	Medically needy income standard			
	○	The special income level for institutionalized persons *(select one):*			
		○	300% of the SSI Federal Benefit Rate (FBR)		
		○	%	of the FBR, which is less than 300%	
		○	$	which is less than 300%.	
	○	%	of the Federal poverty level		
	X	Other :			
		An amount which represents the sum of (1) the income standard used to determine eligibility and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase.			
○	The following dollar amount:		$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:				

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
	○	SSI standard
	○	Optional State supplement standard
	○	Medically needy income standard

	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
○	Not applicable			

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the
	need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.		
○	The amount is determined using the following formula:		
○	Other :		
○	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

X	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits :

c-2 Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
    - [ ]
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ [ ] % of the FBR, which is less than 300%
    - ○ $ [ ] which is less than 300% of the FBR
  - ○ [ ] % of the Federal poverty level
  - ○ Other :
    - [ ]
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:
  - [ ]

ii. Allowance for the spouse only (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
  - [ ]

  Specify the amount of the allowance:
  - ○ The following standard under 42 CFR §435.121:
    - [ ]

	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
○	Not applicable			

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard			
○	Medically needy income standard			
○	The following dollar amount:	$	The amount specified cannot exceed the higher	
	of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.			
○	The amount is determined using the following formula:			
○	Other :			
○	Not applicable (see instructions)			

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits :

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
X	Other **:**		
	An amount which represents the sum of (1) the income standard used to determine eligibility and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase.		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*			
○	Allowance is the same		
○	Allowance is different. Explanation of difference:		

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
X	The State does not establish reasonable limits.
O	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	One	
ii.	**Frequency of services**. The State requires *(select one)*:	
	X	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

X	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other :

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurse (RN), licensed in the State and who is an employee of CDHS/IHO. A physician (M.D. or D. O.) licensed in the State and who is an employee of CDHS/IHO.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The criteria used for waiver LOC is determined by criteria established in Title 22, CCR Division 3, Sections 51173.1 51120, 51124, 51124.5, 51125.6, 51334 and 51335 as well as information submitted on Treatment Authorization Requests (TARs) which support medical necessity for the services as defined in Title 22, CCR Section 51003. Together this information is used during the initial and ongoing reevaluations of all waiver services provided through the NF/AH Waiver.

This waiver will serve disabled Medi-Cal beneficiaries, who would, in the absence of this waiver, and as a matter of medical necessity, pursuant to W&I Code section 14059, otherwise require care in a health care facility providing the following types of care:

1. NF Level A services, pursuant to Title 22, CCR, Section(s) 51120 and 51334,
2. NF Level B services pursuant to Title 22, CCR, Section(s) 51124 and 51335,
3. NF Subacute services, pursuant to Title 22, CCR Section 51124.5 or
4. NF Pediatric Subacute services, pursuant to Title 22, CCR, Section 51125.6
5. Acute Hospital LOC waiver services, pursuant to Title 22, CCR, Sections, 51344 and 51173.1

The Case Report described in Appendix B-6:3 is used after the initial evaluation and later reevaluations to document if the participant continues to meet waiver requirements. The Case Report is reviewed by the CDHS/IHO NE Supervisor to determine if the CDHS/IHO NE's LOC determination is correct and that the home safety evaluation was performed and completed. Complex LOC determinations are reviewed by the CDHS/IHO Medical Consultant, a licensed physician. On

approval of the LOC determination, the Case Report is signed by both the CDHS/IHO NE and CDHS/IHO NE Supervisor.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The CDHS/IHO NE conducts a complete LOC evaluation/reevaluation of the participants for waiver services. The initial evaluation and reevaluations for LOC are documented in the Case Report. The evaluation and reevaluations include identification of an attending physician who provides the participant's specific written orders; a complete and accurate written medical record including diagnoses, history, physical assessment, treatment plan, and prognosis', confirmation that a medical need exists for the level of services requested, and a determination that the services to be provided will maintain program cost neutrality.

For a complete description of the LOC criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver, refer to Appendix B Section 1.b. Individuals or their legal representative (s) or circle of support interested in enrolling in the NF/AH Waiver are required to submit a completed HCBS Waiver Questionnaire. The HCBS Waiver Questionnaire is an instrument that enables persons seeking home and community-based services to provide demographic information and describe their medical care needs.

After the individual and/or his/her legal representative(s) or circle of support completes and returns the HCBS Waiver Questionnaire to IHO, the Questionnaire is assigned to a CDHS/IHO NE. The CDHS/IHO NE reviews the HCBS Waiver

Questionnaire to determine if the individual's medical care needs meet the waiver enrollment criteria. If, after review of the HCBS Waiver Questionnaire, the individual appears to meet the waiver LOC, the CDHS/IHO NE schedules a face-to-face home visit to assess the individual's medical care needs.

Once the initial home visit is completed, the CDHS/IHO NE uses the Case Report to document the individual's LOC and medical care needs, including identification of caregivers, and support systems; a home safety evaluation; and concerns or issues identified by the individual, his/her circle of support, or caregivers needing resolution before the individual can be enrolled into the waiver. The Case Report also documents plans for resolution of issues identified during the evaluation for waiver enrollment. The CDHS/IHO NE provides a justification and recommendation for the individual's LOC in the Case Report.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

O	Every three months
O	Every six months
O	Every twelve months
X	Other schedule :

The CDHS/IHO NE uses the Case Management Acuity System to determine the periodicity of LOC reevaluations and the intensity of the required participant case management. Information collected during the initial evaluation and later reevaluations for LOC is documented in the Case Report and is used to determine a participant's level of case management. NF/AH waiver participants are assigned a level of case management of 1-4, which is based on factors such as a participant's medical stability, compliance with the POT, issues affecting participant health and safety, and availability and adequacy of staffing for waiver services. The CDHS/IHO NE will conduct on-site home visits based upon the level of case management acuity, or as necessary, to assess the effectiveness of the home program in ensuring the participant's health and safety and adherence to the POT.

- Participants assigned ***Level 1*** are reevaluated at least once every 365 days. Level 1 participants are medically stable, have not recently been hospitalized for emergent care, and have no eligibility or staffing issues.
- ***Level 2*** participants are reevaluated more often, at least every 365 days, and up to 180 days. Participants have minor staffing or durable medical

	equipment issues, which are addressed timely by the HCBS provider responsible for rendering waiver case manager services. The waiver case manager maintains regular contact with the CDHS/IHO NE, providing updates to the POT and/or documentation of the issues, corrective actions taken, and outcomes. • ***Level 3*** participants are reevaluated at least every 180 days. Participants assessed at Level 3 can be dependent on medical technology, elected to have non-licensed providers render all of their direct-care services, have high turnover of waiver providers, have had four or more unscheduled hospitalizations in the previous 12 month period, and/or had difficulty in obtaining physician ordered medically-necessary services. The CDHS/IHO NE will assist the participant and/or his/her legal representatives and/or circle of support and waiver case manager in identifying areas of concern and taking corrective actions, and will monitor the outcome. • ***Level 4*** participants are reevaluated at least once every 180 days or more frequently. Level 4 participants require frequent monitoring and interventions by the CDHS/IHO NE to address issues that affect their health and safety. Participants evaluated at level 4 may have related issues suspected or reported domestic violence, abuse, neglect, or exploitation, or a lack of providers to meet their medical care needs and ensure their health and safety. The CDHS/IHO NE conducts frequent on-site visits to work with the participant and/or his/her legal representative(s) and/or circle of support and the HCBS provider responsible for rendering waiver case manager services in response to issues requiring a plan of correction and follow-up.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are :

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care:

Monthly reports are generated from an IHO database. The database tracks the date of last evaluation and the date when the participant requires a reevaluation. Monthly tracking reports are distributed to the CDHS/IHO NEs and the CDHS/IHO NE Supervisors for workload planning and scheduling of home visits to ensure the timeliness of the reevaluation visits.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The LOC evaluation records and reevaluations are maintained in a participant's case record file with the assigned CDHS/IHO NE.

Appendix B-7: Freedom of Choice

***Freedom of Choice**. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver participants and/or their legal representative(s) are informed of the right to accept or decline waiver enrollment and waiver services during the initial evaluation and later revaluations for continued enrollment in the NF/AH Waiver. Information is provided verbally and in writing through use of the "Freedom of Choice" form and "Informing Notice" letter.

A signed "Freedom of Choice" form is required of all participants at the onset of waiver enrollment and before authorization of waiver services or when declining waiver services. After initial evaluation for NF/AH waiver enrollment, the CDHS/IHO NE sends to the participant and/or his/her legal representative(s) a "Freedom of Choice" letter and form for their signature. The participant's and/or his/her legal representative(s)' signature is acknowledgment that the CDHS/IHO NE has described the services available under the NF/AH waiver which are provided as an alternative to care in a licensed heath care facility. The "Freedom of Choice" letter advises the participant and/or his/her legal representative(s) of the right to utilize qualified waiver service providers of their choice.

Enclosed with the "Freedom of Choice" form and letter is the "Informing Notice" which describes the roles and responsibilities of the participant, his/her legal representatives, the waiver providers, and the treating physician. The "Informing Notice" is resent whenever there is a change in the provider of service or the participant's physician.

The participant and/or his/her legal representative(s) are advised to return the signed and dated "Freedom of Choice" form within five days of receipt.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed HCBS "Freedom of Choice" form is maintained in the participant's case record file at the designated IHO office.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The following is representative of the Department:

Medi-Cal statewide threshold languages are: Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, other Chinese, Russian, Spanish, Tagalog, and Vietnamese. A "threshold" is defined as "3,000 beneficiaries or 5% of the Medi-Cal population, whichever is lower, whose primary language is other than English."

In addition to translated materials, CDHS offers Limited English Proficient (LEP) individuals the opportunity to request an interpreter to translate, furnish translation aids, or translate written materials and will ensure that there is no significant delay in services. These services are provided at no cost.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services		
Service	Included	Alternate Service Title (if any)
Case Management	**X**	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	**X**	Home and Community-Based Services Personal Care Benefit
Adult Day Health	☐	
Habilitation	**X**	Habilitation Services
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	☐	
Home Respite	**X**	
Facility Respite	**X**	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Community Transition Services
b.	Environmental Accessibility Adaptations
c.	Family Training
d.	Personal Emergency Response Systems
e.	Personal Emergency Response Systems - Installation and Testing
f.	Private Duty Nursing, including shared services
g.	Transitional Case Management
h.	Medical Equipment Operating Expenses
i.	Waiver Service Coordination

Extended State Plan Services *(select one)*	
X	Not applicable
○	The following extended State plan services are provided:
a.	
b.	

Supports for Participant Direction *(select one)*	
○	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
X	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:	
a.	
b.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c*.
X	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

A California Department of Health Services (CDHS)/In-Home Operations (IHO) Nurse Evaluator (NE), licensed as a Registered Nurse (R.N.) in the State of California and employed by IHO, provides administrative case management services. The CDHS/IHO NE is assisted by the CDHS/IHO Medical Consultant, a licensed physician (M.D. or D.O.) employed by the Home and Community-Based Services (HCBS) Branch who provides medical consultant services to IHO.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

○	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
X	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
X	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

X	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following:

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	☐	☐	☐	☐
Physical environment	☐	☐	☐	☐
Sanitation	☐	☐	☐	☐
Safety	☐	☐	☐	☐
Staff: resident ratios	☐	☐	☐	☐

Staff training and qualifications	☐	☐	☐	☐
Staff supervision	☐	☐	☐	☐
Resident rights	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐
Use of restrictive interventions	☐	☐	☐	☐
Incident reporting	☐	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are

	employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
X	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	Under certain very limited circumstances, a parent, stepparent, foster parent of a minor, a spouse or legal guardian of a waiver participant, hereto referred to as legal representative, may provide select Nursing Facility/Acute Hospital (NF/AH) Waiver services. IHO will authorize the participant's legal representative to provide NF/AH Waiver services upon evidence the legal representative: 1) has an active Medi-Cal provider number with a HCBS waiver category of service indicator; 2) meets waiver licensing and/or certification requirements; 3) meets the HCBS provider standards described in Appendix C-4; 4) meets the NF/AH Waiver Standards of Participation (SOP); and 5) provides evidence of the inability to hire a local licensed professional who meets the service requirements in the participant's plan of treatment. The evidence of inability to hire a local licensed professional must document that: 1) there are no available providers; 2) the participant lives in a remote or rural area experiencing shortages of licensed professionals; 3) the participant's waiver cost neutrality can be achieved or maintained only by using the legal representative as the provider of the HCBS waiver service; 4) attempts were made to enlist and retain a qualified provider, such as the posting of classified advertisements, or contacting home health agencies or

	professional corporations; and 5) there is an accounting of interviews with potential providers including the reasons the provider was not selected or refused to provide the waiver service(s). Legal representatives who meet the Medi-Cal and NF/AH Waiver provider standards may provide the following NF/AH Waiver services: • Case Management; • Community Transition Services; • Environmental Accessibility Adaptations; • Family Training; • Private Duty Nursing; • Habilitation Services; • Respite Home; • Transitional Case Management; • Medical Equipment Operating Expense; and • Waiver Service Coordination. IHO will notify the waiver participant and/or his/her legal representative of the decision to approve or deny the legal representative's request to provide waiver services by either authorizing the requested service(s) or issuing a Notice of Action (NOA).
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Continuous and open enrollment is afforded to any willing and qualified provider who meets Medi-Cal and NF/AH Waiver provider qualifications. Licensed providers must demonstrate they meet applicable state licensure requirements. Non-licensed providers must demonstrate they have been trained to provide services as described on the POT. Information on how interested providers can become a NF/AH Waiver provider is available online at the Medi-Cal website under the Provider Enrollment Branch (PEB). It is also in the Medi-Cal Provider Manual, provided at statewide IHO presentations, and available on request. IHO has expedited the provider enrollment process to ensure waiver participants have timely access to the NF/AH Waiver providers of his/her choice. PEB and IHO have developed a provider information packet for licensed providers that includes:

- NF/AH Waiver Standards of Participation;
- Medi-Cal Provider Application forms and instructions;
- Forms and instructions for requesting authorization to provide NF/AH Waiver services;
- Forms and instructions for submitting claims for payment of approved NF/AH Waiver services that have been rendered; and
- Information on who to contact for questions or problems.

The provider is instructed to return the completed provider application to IHO. IHO reviews the application to determine if the provider meets the waiver's SOP. Upon approval, IHO transmits the application to PEB who will determine if the provider meets the Medi-Cal provider requirements. Upon PEB approval, the provider is issued a Medi-Cal provider number with the category of service code that allows them to render and be reimbursed for NF/AH Waiver services. The expedited provider enrollment process is often completed within 21 working days of PEB's receipt of the application.

Annually, the CDHS/IHO NE verifies that the provider of waiver services continues to meet the waiver program requirements through onsite provider visits and a review of the provider status in the Medi-Cal Eligibility Data System (MEDS) for licensed providers, and Case Management Information Payrolling System (CMIPS) for non-licensed providers.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Case Management**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Case management services are designed to assist waiver participants in gaining access to needed services, regardless of the funding source, to ensure the participant's health and safety and support of his/her home and community-based program. Case managers work with the participant, his/her legal representative and/or circle of support, and physician in assessing needed services, the number of hours requested for each service, and in the development and updating of the participant's POT. Case managers also oversee the implementation of the services described in the POT, and evaluate the effectiveness of those services. Case management responsibilities include assessing, care planning, locating, coordinating, and monitoring services for community-based participants on the waiver. HCBS RN providers providing case management services also supervise, monitor, and train HCBS LVN providers of private duty nursing services. Waiver participants may select case management services for monitoring and training his/her HCBS Personal Care (HCBSPC) benefit providers. A HCBSPC provider is an individual employed directly by the waiver participant receiving HCBSPC services.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
None	

Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
		HCBS Registered Nurse		Home Health Agency
		HCBS Benefit Provider		Professional Corporation
				Non-Profit Agency
Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §§1409-1419.4		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980-4989 Title 16, §§1829-1848		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		NF/AH Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §§74659 et seq. **RN** BPC §§2725 et seq. Title 22, §51067; Title 16, §§1409-1419.4		
Professional Corporation	CC §13401(b)		NF/AH Waiver Standards of Participation
Non-Profit Agency	Business license, appropriate for the services purchased		NF/AH Waiver Standards of Participation (Licensed Professionals only)

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Home and Community-Based Services Personal Care Benefit**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

The Home and Community-Based Services Personal Care (HCBSPC) benefit is designed to assist the waiver participant in gaining independence in his/her activities of daily living and preventing social isolation. These services are supportive, health-related, and specific to the needs of medically stable, disabled persons meeting the criteria of this waiver. Supportive services are those that assist the waiver participant in remaining in his/her residence and continuing to be part of the community. HCBSPC benefits must be described in the participant's POT, which must be signed by the participant or his/her legal representative(s) or circle of support, the participant's physician, and each HCBSPC benefit provider. A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care program in order to be eligible for HCBSPC benefits. Waiver participants whose complex medical care needs meet the acute hospital facility level of care (LOC), requiring frequent evaluation and/or intervention by a Registered Nurse (RN) or Licensed Vocational Nurse (LVN) who is skilled and knowledgeable in evaluating the participant's medical needs and administering technically complex care as ordered by the participant's physician, will not be eligible for this service. This requirement is compliant with the California Business and Professions Code, section 2725 et seq.

The HCBSPS benefit includes:

- Assistance to Independence in Activities of Daily Living (ADL): Assisting the participant in reaching a self-care goal, the HCBSPC benefit provider promotes the participant's ability in obtaining and reinforcing his/her highest level of independence in ADLs. The HCBSPC benefit provider provides assistance and feedback to the participant in an effort to help him/her reach specific self-care goals in performing or directing his/her caregivers in an activity without assistance from others. Services provided by the HCBSPC benefit provider are verbal cueing, monitoring for safety and completeness, reinforcement of the participant's attempt to complete self-directed activities, advising the primary caregiver of any problems that have occurred; providing information for updating the participant's POT and addressing any self-care activities with an anticipated goal completion date.
- Adult Companionship: Adult companionship is for waiver participants who are isolated and/or may be homebound due to his/her medical condition. Adult companions must be at least 18 years of age and able to provide assistance to participants enrolled in the waiver. Waiver participants utilizing Adult Companionship must be at least 18 years old. Adult Companion services include non-medical care, supervision, and socialization provided to a waiver participant who is enrolled and receiving State Plan personal care services authorized under Welfare and Institutions (W&I) Code section 14132.95. To help maintain waiver participant's psychological well-being, adult companions may assist waiver participants in accessing self-interest activities or accessing activities in the local community for socialization and recreational purposes, and/or providing or supporting an environment conducive to interpersonal interactions. Adult companionship must be documented on the POT and identify a therapeutic goal

Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
None					
Provider Specifications					
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:	
	HCBS Personal Care Benefit Provider		Employment Agency		
			Home Health Agency		
			Personal Care Agency		
Specify whether the service may be provided by:	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License	Certificate	Other Standard
HCBS Personal Care Benefit Provider	NA	NA	County IHSS Program Standards & NF/AH Waiver Standards of Participation
Employment Agency	California Business License		County IHSS Program Standards & NF/AH Waiver Standards of Participation
Home Health Agency	Title 22, §§74659 et seq.		County IHSS Program Standards
Personal Care Agency	California Business License		County IHSS Program Standards & NF/AH Waiver Standards of Participation

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Unlicensed Individual	IHO Nurse Evaluator	Every 6 months

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Habilitation Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Habilitation Services are provided in a participant's home or an out-of-home non-facility setting designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Habilitation services include training on: the use of public transportation; personal skills development in conflict resolution; community participation; developing and maintaining interpersonal relationships; personal habits; daily living skills (cooking, cleaning, shopping, money management) and community resource awareness such as police, fire, or local services to support independence in the community. It also includes assistance with: locating, using and caring for canine and other animal companions specifically trained to provide assistance; selecting and moving into a home; locating and choosing suitable housemates; locating household furnishings; settling disputes with landlords; managing personal financial affairs; recruiting, screening, hiring, training, supervising, and dismissing personal attendants; dealing with and responding appropriately to governmental agencies and personnel; asserting civil and statutory rights through self-advocacy, and building and maintaining interpersonal relationships, including a circle of support.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
None	

Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
		HCBS Registered Nurse		Home Health Agency
		HCBS Benefit Provider		Professional Corporation
		Physical Therapist		Non-Profit Agency
		Occupational Therapists		
		Speech-Language Pathologist		

Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §§1409-1419.4		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980–4989 Title 16, §§1829-1848		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		NF/AH Waiver Standards of Participation

Home Health Agency – Registered Nurse	**HHA** Title 22, §§74659 et seq. **RN** BPC §§2725 et seq. Title 22, §51067; Title 16, §§1409-1419.4		
Professional Corporation	CC §13401(b)		NF/AH Waiver Standards of Participation
Non-Profit Agency	Business license, appropriate for the services purchased		NF/AH Waiver Standards of Participation
Physical Therapist	BPC §§2600 et seq. Title 16, §§1398 et seq.		
Occupational Therapists	BPC §§2570 et seq. Title 16, §§4100 et seq.		
Speech-Language Pathologist	BPC §§2530 et seq. Title 16, §§1399.150 et seq.		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
Physical Therapist	Physical Therapist Board of California	Biennially
Occupational Therapist	California Board of Occupational Therapy	Annually
Speech-Language Pathologist	California Speech-Language Pathology and Audiology Board	Biennially

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Home Respite**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

The Home Respite benefit is intermittent or regularly scheduled temporary medical and/or non-medical care supervision provided to the participant in their own home to do the following:

1. Assist family members in maintaining the participant at home;
2. Provide appropriate care and supervision to protect the participant's safety in the absence of family members or caregivers;
3. Relieve family members from the constantly demanding responsibility of caring for a participant; and
4. Attend to the participant's medical and non-medical needs and other ADLs, which would ordinarily be performed by the service provider or family member.

The Home Respite benefit, as authorized, is to temporarily replace non-medical care that was provided to the participant by his/her legal representative(s), and/or circle of support for a scheduled period of time as previously authorized by IHO.

Waiver participants whose complex medical care needs meet the acute hospital facility LOC, requiring frequent evaluation by a licensed provider(s) who is skilled in and knowledgeable in evaluating the participant's medical needs and administering technically complex care as ordered by the participant's physician, are not eligible to receive Home Respite services provided by an unlicensed provider. This requirement is consistent with the California Business and Professions Code, section 2725 et seq.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
		HCBS Registered Nurse		Home Health Agency
		HCBS Licensed Vocational Nurse		Employment Agency
		HCBS Personal Care Benefit Provider		Personal Care Agency
Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Personal Care Benefit Provider	NA	NA	County IHSS Program Standards & NF/AH Waiver Standards of Participation
Employment Agency	California Business License		County IHSS Program Standards & NF/AH Waiver Standards of Participation
Personal Care Agency	California Business License		County IHSS Program Standards & NF/AH Waiver Standards of Participation
Home Health Agency Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Home Health Agency Licensed Vocational Nurse	**HHA** Title 22, §74659 et seq. **LVN** BPC §§2859-2873.7 Title 22, §51069;		

Home Health Agency Certified Home Health Aide	**HHA** Title 22, §§74659 et seq.	**CHHA** BPC §§2725-2742 Title 22, §51067	
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §§51067; Title 16 §§1409-1419.4		NF/AH Waiver Standards of Participation
HCBS Licensed Vocational Nurse	BPC §§2859-2873.7 Title 22, §51069;		NF/AH Waiver Standards of Participation

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Unlicensed Individual	IHO Nurse Evaluator	Every 6 months
Certified Home Health Aide	DHS Licensing and Certification	Biennially
Licensed Vocational Nurse	California Board of Vocational Nursing and Psychiatric Technicians	Biennially
Registered Nurse	California Board of Registered Nursing	Biennially

Service Delivery Method

Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Facility Respite**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
The Facility Respite benefit services is provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. These services are provided in an approved out-of-home location to do all of the following: 1. Provide appropriate care and supervision to protect the participant's safety in the absence of family members; 2. Relieve family members from the constantly demanding responsibility of caring for a participant; and 3. Attend to the participant's medical needs and other ADLs, which would ordinarily be the responsibility of the service provider or family member.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
None	

Provider Specifications				
Provider Category(s)**:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				HCBS Nursing Facility
				Nursing Facility A/B
				Nursing Facility Subacute
				Nursing Facility Distinct Part

Specify whether the service may be provided by*:*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License	Certificate	Other Standard
HCBS Nursing Facility	HSC §§1250 et seq. Title 22, §§51246 et seq.		NF/AH Waiver Standards of Participation
NF A/B	HSC 1250 et seq. Title 22, §72301		
NF SA	HSC 1250 et seq. Title 22, §72301		
NF DP	HSC 1250 et seq. Title 22, §72301		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
HCBS Nursing Facility	DHS Licensing and Certification	Biennially
NF A/B	DHS Licensing and Certification	Biennially
NF SA	DHS Licensing and Certification	Biennially
NF DP	DHS Licensing and Certification	Biennially

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Community Transition Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from a licensed health care facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include: a) security deposits that are required to obtain a lease on an apartment or home; b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; e) moving expenses; f) necessary home accessibility adaptations; and g) activities to assess, arrange for, and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary. Documentation must be clearly identified in the POT that these services cannot be obtained from other sources as determined through the POT development process. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

The lifetime maximum allowed cost for Community Transition Services is $5,000.00. It is the responsibility of the CDHS/IHO NE to explain to the participant the guidelines of the Community Transition Services under the waiver. The use of this service will necessarily result in a reduction in other waiver services the participant may receive during the same year Community Transition Services are authorized. The participant's waiver costs must be cost neutral to the inpatient alternative. The participant should understand the possible fiscal impact of receiving this service at the time of request for the Community Transition Services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00.

Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
		HCBS Registered Nurse		Home Health Agency
		HCBS Benefit Provider		Professional Corporation
				Non-Profit Agency
Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980-4989 Title 16, §§1829-1848		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		NF/AH Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Professional Corporation	CC §13401(b)		NF/AH Waiver Standards of Participation

Non-Profit Agency	Business license, appropriate for the services purchased		NF/AH Waiver Standards of Participation
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Registered Nurse	California Board of Registered Nursing		Biennially
Marriage Family Therapist	California Board of Behavioral Sciences		Annually
Licensed Psychologist	California Board of Psychology		Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences		Annually

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Environmental Accessibility Adaptations**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Environmental Accessibility Adaptations are those physical adaptations to the home, identified in the participant's POT, that are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the safety and welfare of the participant. All services shall be provided in accordance with applicable State or local building codes.

All Environmental Accessibility Adaptations are subject to prior authorization by the CDHS/IHO NE. Requests for any modifications to a residence, which is not the property of the waiver recipient, shall be accompanied by written consent from the property owner for the requested modifications. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

If there is no written authorization from the owner, environmental accessibility will not be authorized or be subject to compensation for residential care providers or rental units. To the extent possible, the participant will make modifications to the residence prior to occupation. Upon commencement of the modifications, all parties will receive written documentation that the modifications are permanent, and that the State is not responsible for removal of any modification if the participant ceases to reside at a residence.

All requests for Environmental Accessibility Adaptations submitted by a provider should include the following:

1. Physician's order specifying the requested equipment or service;
2. Physical or Occupational Therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. This should typically come from an entity with no connection to the provider of the requested equipment or service. The Physical or Occupational Therapy evaluation and report should contain at least the following:
   a. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;
   b. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and
   c. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.
3. A Medical Social Worker evaluation and report to evaluate other possible community resources available to provide the requested equipment or service, the availability of the other resources, and any other pertinent recommendations related to the requested equipment or service. This should include the description of the availability of Other Health Coverage (OHC) to provide for the requested equipment or service;
4. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary;
5. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and,

The CDHS/IHO NE will adjudicate the TAR after all requested documentation has been received and reviewed, and a home visit has been conducted by appropriate program staff to determine the suitability of any requested equipment or service.

The lifetime maximum allowed cost for Environmental Accessibility Adaptations is $5,000.00. It is the responsibility of the CDHS/IHO NE to explain to the participant the guidelines of the Environmental Accessibility Adaptation services under the waiver. The use of this service will necessarily result in a reduction in other waiver services the participant may receive during the same year that Environmental Accessibility Adaptations service is authorized. The participant waiver costs must be cost neutral to the inpatient alternative. The participant should understand the possible fiscal impact of receiving this service at the time of request for Environmental Accessibility Adaptations service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environmental Accessibility Adaptation services are payable up to a total lifetime maximum amount of $5,000.00. The only exceptions to the $5,000.00 total maximum are if:

1. The recipient's place of residence changes; or
2. In the opinion of the CDHS/IHO NE, and based upon review of appropriate documentation, the waiver participant's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the participant, or are necessary to enable the participant to function with greater independence in the home and without which, the recipient would require institutionalization.

Provider Specifications

Provider Category(s):				
	X	Individual. List types:	**X**	Agency. List the types of agencies:
		Building Contractor		Non-Profit Agency
		Private Business		Durable Medical Equipment (DME) Provider

Specify whether the service may be provided by:				
	X	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License	Certificate	Other Standard
Durable Medical Equipment (DME) Provider	W&I 14043.15, 14043.2, 14043.25, 14043.26 Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)		Business license appropriate for the services purchased.
Building Contractor	Contractor or business license, appropriate for the services purchased		
Non-Profit Agency	Business license, appropriate for the services purchased		NF/AH Waiver Standards of Participation
Private Business	Business license, appropriate for the services purchased		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Durable Medical Equipment (DME) Provider	DHS, Food and Drug Division	Annually
Building Contractor	IHO Nurse Evaluator	Prior to the authorization of requested services.
Private Individual	IHO Nurse Evaluator	Prior to the authorization of requested services.

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Family Training**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Family Training services are training and counseling for families of waiver participants. For purposes of this service, “family” is defined as persons who live with or provide care to a participant served on the waiver (may include a parent, spouse, children, relatives, foster family, in-laws or other responsible persons who agree to act as an uncompensated caregiver in the absence of a waiver service provider). "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the POT, how to care for the participant in the absence of the paid care providers and includes updates as necessary to safely maintain the participant at home. All family training must be included in the participant's written POT.

Family Training services may only be provided by a RN. Upon request from the participant, his/her family, participant’s physician, provider of services, or the CDHS/IHO NE for family training, the provider of service, must document the training that is needed and the process to meet the need. The provider of the service will submit the documentation and the request to provide family training to the CDHS/IHO NE. The CDHS/IHO NE will review the documentation and authorize when medically necessary to ensure the health and safety of the participant. Upon completion of the training the provider will submit to the CDHS/IHO NE documentation of the results of the training.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications					
Provider Category(s)**:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:	
	HCBS Registered Nurse		Home Health Agency		
Specify whether the service may be provided by*:*	**X**	Legally Responsible Person	**X**	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		NF/AH Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Personal Emergency Response Systems**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

The Personal Emergency Response Systems (PERS) is a 24-hour emergency assistance electronic device that enables certain participants at high risk of institutionalization to secure help in an emotional, physical, or environmental emergency. PERS services are limited to participants who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and would otherwise require routine supervision.

The PERS is connected to the person's telephone and programmed to signal a response center once a "help" button is activated. The participant may wear a portable "help" button permitting greater mobility. The response center is staffed with trained professionals who have access to the participant's profile and critical information. PERS staff immediately attempts to contact the participant to determine if an emergency exists. If one does exist, the PERS staff contacts local emergency response services to request assistance.

The immediate response to a participant's request for assistance can help prevent unnecessary institutionalization of a waiver participant. PERS services will only be provided as a waiver service to a participant residing in a non-licensed environment.

PERS are individually designed to meet the needs and capabilities of the participant. The following services are allowed:

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders;
7. Monitoring services;
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available from the telephone company; and
10. Other electronic devices/services designed for emergency assistance.

All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. Prior authorization for PERS services must be obtained by the waiver service provider from the CDHS/IHO NE.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s)**:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
	Private Business		Non-Profit Agency	
			Professional Corporation	
			Durable Medical Equipment (DME) Provider	
			Home Health Agency	
Specify whether the service may be provided by*:*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
Durable Medical Equipment (DME) Provider	W&I 14043.15, 14043.2, 14043.25, 14043.26 Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)		Business license appropriate for the services purchased.
Non-Profit Agency	Business license, appropriate for the services purchased		NF/AH Waiver Standards of Participation
Professional Corporation	CC §13401(b)		
Home Health Agency	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Private Business	Business license, appropriate for the services purchased		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Durable Medical Equipment (DME) Provider	DHS, Food and Drug Division	Annually
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
Private Individual	IHO Nurse Evaluator	Prior to the authorization of requested services

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Personal Emergency Response Systems – Installation and Testing**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

The Personal Emergency Response System (PERS) installation and testing service is for installation and testing of a PERS for individuals at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to individuals who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require routine supervision.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications				
Provider Category(s)**:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
	Private Business		Non-Profit Agency	
			Professional Corporation	
			Durable Medical Equipment (DME) Provider	
			Home Health Agency	

Specify whether the service may be provided by*:*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License	Certificate	Other Standard
Durable Medical Equipment (DME) Provider	W&I 14043.15, 14043.2, 14043.25, 14043.26 Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)		
Non-Profit Agency	Business license, appropriate for the services purchased		
Professional Corporation	CC §13401(b)		
Home Health Agency	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Private Business	Business license, appropriate for the services purchased		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Durable Medical Equipment (DME) Provider	DHS, Food and Drug Division	Annually
Non-Profit Agency	IHO Nurse Evaluator	Prior to the authorization of requested services.
Private Individual	IHO Nurse Evaluator	Prior to the authorization of requested services.
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Private Duty Nursing, includes shared services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Private Duty Nursing services are individual and continuous care (in contrast to part-time or intermittent care) provided by a licensed nurse or a certified home health aide under a home health agency within the scope of state law. Services are provided to a waiver participant in his/her home or home-like environment.

Shared PDN services are provided to two participants who live at the same residence. Shared PDN services are provided only on request and agreement of the involved participants and/or his/her authorized representative(s).

A HCBS RN provides supervision and monitoring of PDN or Shared PDN services if provided by an HCBS LVN.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

IHO will at no time authorize direct care services or any combination of direct care services exceeding 24 hours of care per day under this waiver. Direct care services include State Plan services, such as In-Home Supportive Services, adult or pediatric day health care, PDN, shared PDN, and/or direct care authorized by OHC. Direct care is hands on care to support the care needs of the waiver participant.

Provider Specifications				
Provider Category(s)**:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	HCBS Waiver LVN		Home Health Agency	
	HCBS Waiver RN		HCBS Nursing Facility	

Specify whether the service may be provided by*:*	**X**	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License	Certificate	Other Standard
HCBS Nursing Facility	HSC §§1250 et seq. Title 22, §§51246 et seq.		NF/AH Waiver Standards of Participation
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		NF/AH Waiver Standards of Participation
HCBS Licensed Vocational Nurse	BPC §§2859-2873.7 Title 22, §51069		NF/AH Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Home Health Agency Licensed Vocational Nurse	**HHA** Title 22, §§74659-74689 **LVN** BPC §§2859-2873.7 Title 22, §51069;		
Home Health Agency Certified Home Health Aide	**HHA** Title 22, §§74659 et seq.	**CHHA** BPC §§1736.1-1736.6	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Congregate Living Health Facility	DHS Licensing and Certification	Annually
Registered Nurse	California Board of Registered Nursing	Biennially

Licensed Vocational Nurse	California Board of Vocational Nursing and Psychiatric Technicians	Biennially
Certified Home Health Aide	DHS Licensing and Certification	Annually

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Transitional Case Management**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Transitional Case Management (TCM) services are provided to transition a Medi-Cal waiver eligible individual from a health care facility to a home and community-based setting. TCM providers will have direct contact with the participant, his/her circle of support and the participant's primary physician to obtain information that will allow the TCM provider to coordinate services such as housing, equipment, supplies, or transportation that may be necessary to leave a health care facility. TCM services may be provided up to 180 days prior to discharge from a health care facility. All TCM services provided will be billed against the waiver on the date of waiver enrollment. If the participant should decease before discharge, the TCM services provided may be claimed as an administrative expense under the State Plan.

TCM service will include an evaluation of the participant's medical and non-medical care needs, circle of support, home setting, and funding sources to support the participant's choice to transition from the facility to a home and community-based setting. The TCM provider will coordinate the transition of services with the participant's waiver case manager and/or waiver service coordinator, when appropriate, upon the individual's enrollment to the waiver.

Requests for this service shall be accompanied by a POT that includes: the participant's medical and non-medical care needs, and plan on how the individual's needs will be met.

The use of this service will necessarily result in a reduction in other waiver services the participant may receive during the same year that Transitional Case Management services are authorized. The participant waiver costs must be cost neutral to the inpatient alternative. The participant should understand the possible fiscal impact of receiving this service at the time of request for Transitional Case Management services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
TCM services may be provided up to 180 days prior to discharge from health care facility. These services will be provided before the individual's enrollment in the waiver.

Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
	HCBS Benefit Provider		Home Health Agency	
	HCBS Waiver RN		Professional Corporation	
			Non-Profit Agency	

Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980– 4989 Title 16, §§1829-1848		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		NF/AH Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		

Professional Corporation	CC §13401(b)		NF/AH Waiver Standards of Participation
Non-Profit Agency	Business license, appropriate for the services purchased		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually

Service Delivery Method

Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Medical Equipment Operating Expenses**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Medical Equipment Operating Expenses are services necessary to prevent reinstitutionalization for waiver participants who are dependent upon medical technology. Medical Equipment Operating Expenses must be described in the participant's POT. Medical Equipment Operating Expenses are limited to utility costs directly attributable to operation of life sustaining medical equipment in the participant's place of residence. For purposes of this waiver service, "life sustaining medical equipment" is defined as: mechanical ventilation equipment and positive airway pressure equipment, suction machines, feeding pumps, and infusion equipment. Notwithstanding this definition, in the event a specific medical need is identified and Medical Equipment Operating Expenses are requested in the POT, IHO will evaluate the request for this service and may grant exceptions to this definition.

The waiver service provider may submit a request for the authorization of this service to IHO for evaluation of the request. After the request has been approved, the waiver service provider may bill Medi-Cal for this service. Upon the provider's receipt of payment, the provider will reimburse the monies to the participant.

In order to calculate the cost per unit of time, the authorization for waiver Medical Equipment Operating Expenses includes consideration of the type of equipment and frequency of use. Cost factors to operate electrical equipment are supplied by local utility companies and are based on a consideration of the equipment's size and voltage and amperage requirement.

The waiver participant's case manager is responsible for notifying the local utility providers that the NF/AH Waiver participant is an individual dependent upon life sustaining medical equipment. Documentation indicating that local utilities have been notified shall be kept in the participant's case record, and updated and revised when necessary by the CHDS/IHO NE.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The minimum monthly claim for utility coverage reimbursement is $20.00, the maximum is $75.00.

Provider Specifications				
Provider Category(s)**:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	HCBS Benefit Provider		Home Health Agency	
	HCBS Waiver RN		Professional Corporation	
			Non-Profit Agency	

Specify whether the service may be provided by*:*	**X**	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980– 4989 Title 16, §§1829-1848		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		NF/AH Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		

Professional Corporation	CC §13401(b)		NF/AH Waiver Standards of Participation
Non-Profit Agency	Business license, appropriate for the services purchased		
Private Business			

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
Private Individual	IHO Nurse Evaluator	Prior to the authorization of requested services

Service Delivery Method

Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Waiver Service Coordination**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Waiver Service Coordination is the coordination of services for participants who have complex medical needs and access to multiple funding sources through public or private entities for needed services to be maintained in home or community-based settings. These multiple funding sources could include Medi-Cal related services, California Children's Services for individuals under the age of 21, Regional Center, Department of Rehabilitation, county funded services, Medicare, and/or private insurance. This service will include educating the participant and/or caregivers about the different funding sources and helping to assist the participant and/or caregivers in understanding the various services he/she is receiving or may receive and the impact, if any, of the services received/requested, based on the source of funding. Waiver Service Coordination will supplement the case management activities authorized under this waiver or through other entities. Waiver Service Coordination activities will not involve the authorization of services, care planning or locating needed services.

Requests for this service shall be accompanied by a POT that shall include the following: the medical and non-medical care needs and expected outcomes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None.

Provider Specifications				
Provider Category(s)**:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	HCBS Benefit Provider		Home Health Agency	
	HCBS Waiver RN		Professional Corporation	
			Non-Profit Agency	

Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980-4989 Title 16, §§1829-1848		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		NF/AH Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		NF/AH Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §§74659 et seq. **RN** BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Professional Corporation	CC §13401(b)		NF/AH Waiver Standards of Participation
Non-Profit Agency	Business license, appropriate for the services purchased		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
X	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals:

X	Registered nurse (RN), licensed to practice in the State
☐	Licensed practical or vocational nurse (LVN), acting within the scope of practice under State law
X	Licensed physician (M.D. or D.O.)
X	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

☐	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	An In-Home Operations (IHO) Home and Community-Based Services (HCBS) Nursing Facility/Acute Hospital (NF/AH) Waiver case management provider who meets the service requirements set forth in Appendix C-3 and in the NF/AH Waiver Standards of Participation may provide other waiver services

described in the Plan of Treatment (POT). The POT must be reviewed and signed by the physician overseeing the participant's home program.

The POT must be current and updated at least every 180 days, or more often when the participant's health status and needs change. The waiver case manager is responsible for submitting the latest POT with each Treatment Authorization Request (TAR) for waiver services.

Before approving the initial authorization or reauthorization for waiver services, the CDHS/IHO NE reviews the POT to determine that the requested waiver services are medically necessary and that the amount, frequency, and duration of each service is included, as well as the provider type. The POT must also document that the participant and/or his/her legal representative(s) participated in the development of the POT and was informed of his/her free choice to select qualified providers.

During the initial and ongoing home visits, the CDHS/IHO NE discusses with the participant and/or his/her legal representative(s) his/her right to freely choose a waiver provider to provide services described in the POT. If the participant and/or his/her legal representative(s) and/or circle of support requests assistance identifying providers of waiver services, the CDHS/IHO NE will give the participant and/or his/her legal representative(s) the Menu of Health Services (MOHS) and a list of local HCBS waiver providers. The MOHS provides information on the different types of waiver services and provider types, and the cost of each service.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) The CDHS/IHO NE provides the waiver participant, and/or his/her legal representative(s), and/or circle of support with information on the purpose of the POT and encourages them to participate in identifying his/her needs, services, and providers to support and ensure the safety of his/her home program. The information is provided verbally at the initial and ongoing face-to-face home visits, as well as in writing through the HCBS Informing Notice and MOHS. During the ongoing home visits, the CDHS/IHO NE reviews the POT with the participant and/or his/her legal representative(s) and/or circle of support to ensure the POT accurately reflects the participant's identified care needs, type and duration of services, and providers of the service.

The CDHS/IHO NE is available to assist the participant and/or his/her legal representative(s) and/or circle of support with information on the State plan and waiver services that can meet his/her identified needs. Participants are encouraged to select waiver providers that are best suited to meet his/her needs, taking into account experience providing direct care services in the home, availability, hours of service, and cultural and linguistic competencies.

The CDHS/IHO NE provides training to HCBS waiver providers, who assist the participant in the development of his/her POT, on the waiver requirement to include the participant and/or his/her legal representative(s) and/or circle of support in the development of the POT. The provider receives this information verbally during the provider visit and in the HCBS Informing Notice that is mailed to the HCBS waiver provider.

The CDHS/IHO NE will work with the participants and his/her legal representative(s) and or circle of support who only choose the HCBS Personal Care Benefit services and who cannot locate a HCBS waiver case manager in the development of a POT that describes all his/her care needs, services, and providers.

(b) Beginning with the application for waiver services and throughout the development of the POT, the participant and/or his/her legal representative and/or circle of support are provided with the opportunity and encouraged to involve individuals of his/her choice in the development of the POT. The "Medi-Cal Home and Community-Based Services Waiver Informing Notice" informs the participant and/or his/her legal representative of his/her authority in determining who can assist them in selecting and identifying waiver services and providers. The Informing Notice includes a complete description of the participant, his/her primary caregivers, the primary care physician, HCBS waiver service providers, and CDHS' roles and responsibilities in the development and implementation of the POT.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The waiver case manager is responsible for developing the POT. A waiver case manager can be:

1. A RN licensed to practice in the State of California, who is an employee of IHO.
2. A RN licensed to practice in the State of California, who is employed by a Home Health Agency or who is under the direction of a licensed physician.
3. A Physician licensed to practice in the State of California who is the participant's treating physician.
4. A Marriage and Family Therapist (MFT), Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), or a professional corporation that employs MFTs, Licensed Clinical Psychologists, and/or LCSWs.

The participant's primary care physician, if different from the treating physician, must participate in the development of the POT.

IHO policies and procedures require that the participant's waiver case manager include the participant and/or his/her legal representative(s) and/or circle of support in identifying the participant's care needs, waiver services, and providers in the development of the POT.

The participant's waiver case manager is responsible for completing the initial POT and updating it at least every 180 days thereafter. If after the completion of the initial POT it is determined that the POT does not meet the participant's needs due to significant changes in the participant's condition, the waiver case manager, consulting with the treating physician, must submit an updated or revised POT to the CDHS/IHO NE. "Significant changes" are changes that

suggest the need to modify the POT, such as changes in the participant's health status, home setting, or availability of waiver providers.

The CDHS/IHO NE monitors the timeliness of the POT. Waiver service providers are required to submit a copy of the current physician-signed POT with each request for authorization of waiver services.

(b) Waiver case managers can use the "Medi-Cal Operations, Home and Community-Based Services, Plan of Treatment" or the CMS-485 Home Health Plan of Care for the POT.

The POT must include the participant's demographic information; treating and primary care physician information; medical information and diagnosis; HCBS waiver program and LOC; all required waiver services, including amount and frequency, and waiver service provider type; state plan services; durable medical equipment required; medication plan; nutritional requirements; the treatment plan for the home program; the participant's functional limitations; permitted activities; mental status; medical supplies; ongoing therapies and therapy referrals; treatment goals, including rehabilitation potential; and training needs for the participant and family.

The waiver case manager completes the POT summarizing the status of the participant during the previous POT period and the effectiveness of the services provided. The participant, and/or his/her legal representative(s), the physician who oversees the home program, and all providers of waiver services sign the completed POT.

The CDHS/IHO NE reviews the completed POT to verify the participant's care needs, the frequency of waiver and state plan services, providers, and the participant's goals. Back-up systems are also identified. The CDHS/IHO NE's review of the POT is conducted during the initial request for NF/AH Waiver services, during the reevaluation of the participant's LOC, at the annual provider visit, and with each request for waiver services. The CDHS/IHO NE may ask for additional documentation supporting the medical necessity of the services described in the POT. Any necessary or suggested revisions of the POT are discussed with the waiver service providers, the treating physician, and participant and/or legal representative(s) and/or circle of support. Modifications to the POT are made only with approval of the participant and/or his/her legal representative and the treating physician.

(c) The CDHS/IHO NE provides information to the participant and/or his/her legal representative(s), and/or circle of support on the NF/AH Waiver and available provider types. This information is provided verbally during the initial and subsequent home visits, and in writing though the Menu of Health Services

(MOHS). The MOHS lists all the waiver services and provider types available to the participant. The MOHS is a planning instrument that is used by the participant and/or his/her legal representative, circle of support and CDHS/IHO NE in the development of a home care program, and to ensure the home program meets the NF/AH Waiver cost neutrality requirements. The participant and/or his/her legal representative(s) and/or his/her circle of support are encouraged to select the waiver service best suited to meet his/her needs during the completion of the MOHS. The participant and/or his/her legal representative(s), and/or circle of support are advised to contact, by telephone or in writing, the CDHS/IHO NE when they have questions regarding waiver services and/or providers.

(d) The POT process is designed to document the participant and/or his/her legal representative(s) and/or circle of support goals for successfully living at home in the community. Waiver participants are encouraged to participate in the development of the POT, choosing waiver services, providers, and treatment options that will assist them in meeting the stated goals. The participant and/or his/her legal representative(s) and waiver service providers responsible for the services specified in the plan must sign the completed POT. The CDHS/IHO NE reviews the effectiveness of meeting the goals described in the POT during the LOC reevaluation home visit.

(e) The waiver case manager is primarily responsible for assisting the participant with coordination of waiver and state plan services. The waiver case manger regularly updates the POT, documenting changes in the participant's health status and identifying waiver and non-waiver services needed for the participant to remain safely at home. The waiver case manager can assist the participant and/or his/her legal representative(s) and/or members of the circle of support identify providers, or other necessary services. Participants in the NF/AH Waiver can elect to use Waiver Service Coordination services for assistance in identifying community resources and services not available through the waiver or the state plan that will meet their needs.

The CDHS/IHO NE can also assist the participant and/or his/her legal representative(s) and/or circle of support and waiver case manager to identify local resources, provided by non-governmental organizations or state and local government agencies, for transportation, housing, and nutrition services.

(f) The POT requires the waiver case manager to identify waiver services, waiver providers, and the amount and frequency of waiver services. The waiver case manager is responsible for making certain that services are provided in accordance with the POT. The CDHS/IHO NE reviews the POT while conduct

the LOC reevaluation. During the reevaluation, the CDHS/IHO NE reviews the POT with the participant and/or his/her legal representative(s) and/or members of the circle of support to identify any problems in the home care program. The waiver case manager is required to be present during the participant's scheduled reevaluation. Annually, the CDHS/IHO NE conducts the provider visit with the waiver case manager to review the participant case record and the participant's home program, including implementation of the elements of the POT. The CDHS/IHO NE, together with the participant and/or his/her legal representative(s) and/or circle of support, and waiver case manager prepares a plan of correction for issues identified during the reevaluation or the annual provider visit.

(g) After the completion of the initial POT, if it is determined that the POT does not meet the participant's needs due to significant changes in the participant's condition, the waiver case manager, consulting with the treating physician, must submit an updated or revised POT to the CDHS/IHO NE. "Significant changes" are changes that suggest the need to modify the POT such as changes in the participant's health status, home setting, or availability of waiver providers.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The POT documents the waiver case manager's nursing evaluation and proposed interventions enabling the participant to live safely at home in the community. The CDHS/IHO NE reviews the POT, taking into account the participant's medical condition and care need(s), and verifies the POT is signed by the waiver case manager service provider and the responsible physician. The physician's signature is evidence that the physician has reviewed the POT, agrees that it addresses the participant's health care needs so that he/she can live safely at home in the community.

The POT is developed based on information obtained from the nursing evaluation and the home safety evaluation. The latter demonstrates that the participant's home environment is safe and conducive to the successful implementation of a home and community-based services program. It includes an evaluation of risk factors affecting the participant's health and safety (e.g. sufficient care providers trained in the participant's care needs, effective back-up plan, evaluation for

abuse, neglect and exploitation). Identified conditions that may affect the participant's health, welfare, and/or safety require the waiver case manager to develop a plan of correction and provide evidence that the conditions are corrected. An approved POT will include the following information:

- Assurance that the area where the participant will be cared for can accommodate the use, maintenance, and cleaning of all medical devices, equipment, and storage supplies necessary to maintain the participant in the home in comfort and safety, and to facilitate the nursing care required;
- Assurance that primary and back-up utility, communication, and fire safety systems and devices are available, installed, and in working order, including grounded electrical outlets, smoke detectors, fire extinguisher, and telephone services;
- Evidence that local emergency and rescue services and utility services have been notified that a person with special needs resides in the home;
- Assurance that all medical equipment, supplies, primary and back-up systems, and other services and supports, are in place and available in working order, or have been ordered and will be in place at the time the participant is placed in the home;
- Documentation that the participant is not subjected to abuse, neglect, or exploitation and is knowledgeable of his/her rights and who to contact if incidents occur; and
- Documentation that the caregivers are knowledgeable of the care needs of the participant.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants receiving services through the NF/AH Waiver can select any Medi-Cal provider who is willing to provide State Plan or waiver services. The CDHS/IHO NE provides the participant and/or his/her legal representative(s) and/or members of his/her circle of support with a list of current HCBS waiver providers and information on how a non-HCBS waiver provider can enroll as a waiver provider. Additionally, the CDHS/IHO NE provides the participant and/or his/her legal representative(s) with the MOHS, which includes the provider types authorized to provide approved waiver services.

Waiver participants are encouraged to identify providers of waiver services that

can best meet his/her needs. Factors considered should include a provider's experience, abilities, and availability to provide services in a home and community-based setting, as well as the ability to work with the participant's other caregivers, the primary care physician, and the CDHS/IHO NE. When needed, the CDHS/IHO NE can assist the participant and/or legal representatives in locating waiver service providers.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The CDHS/IHO NE is responsible for approving the POT. A current POT must be submitted to IHO at the initial waiver enrollment and with each TAR for authorization of waiver services. The CDHS/IHO NE reviews the POT with the participant and/or legal representative(s), and/or circle of support, during each home visit and with the HCBS waiver providers during the annual visit. POTs not meeting the NF/AH Waiver standards are returned to the waiver case manager with instructions regarding needed revisions or additional information required. The revised POT must be sent to the participant's physician for review and signature. Enrollment in the NF/AH Waiver or authorization for requested waiver services will not be completed until the POT is revised and accurately reflects the participant's needs, services, providers, goals, and identifies and corrects safety issues.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
X	Every six months or more frequently when necessary
○	Every twelve months or more frequently when necessary
○	Other schedule :

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following:

X	Medicaid agency
☐	Operating agency
X	Case manager
☐	Other *:*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed

(a) The CDHS/IHO NE and waiver case manager are responsible for monitoring the implementation of the POT, and ensuring that it accurately reflects the participant's care needs, and that the participant is receiving the described waiver services.

(b) The CDHS/IHO NE and waiver case manager ensure that waiver services are furnished in accordance with the POT by maintaining regular contact with the participant and/or his/her legal representative and/or circle of support. Contact includes home visits and telephone calls. The waiver case manager is responsible for regularly apprising the CDHS/IHO NE of the participant's status and reporting any unforeseen issues or problems that could negatively affect the participant.

The waiver case manager is responsible for maintaining participant case notes documenting the participant's health status and identified problems and issues. The waiver case manager is responsible for documenting plans of correction and resolution of identified problems or issues regarding implementation of the participant's POT or his/her health and welfare. The CDHS/IHO NE regularly reviews the waiver case manager's case notes and documentation to ensure that any plan of correction was completed with appropriate follow-up. During regularly scheduled meetings with the participant and/or his/he legal representative(s) and/or circle of support, the CDHS/IHO NE asks if they are satisfied with the plan of correction and resolution.

At the home visit, the CDHS/IHO NE reviews the POT with the participant and/or his/her legal representative(s) and/or members of his/her circle of support to:

- Verify the participant's POT is current and signed by the treating physician. Copies of the current and past POTs are filed in the participant's case record.
- Verify the participant is receiving the services described in the POT, review the POT with the participant and/or his/her legal representatives and/or members of his/her circle of support and discuss the recommendations for waiver and non-waiver services and providers of services.

- Ensure the POT meets the participant's health care needs and personal goals. During the on-site home visit the CDHS/IHO NE attempts to determine if the participant is receiving all the services identified in the POT, whether the participant is satisfied with the care being delivered, and if the participant is receiving the services needed to remain safely at home.
- Ensure a complete and accurate written medical record, including diagnoses, complete evaluation, treatment plan, and prognosis is available when determining the need for the HCBS waiver services described in the POT.
- Determine that waiver and non-waiver State Plan services provided do not exceed the waiver cost neutrality.
- Review the back-up plan in the event a provider is not available. The CDHS/IHO NE can assist the participant and/or his/her legal representatives and/or members of his/her circle of support in identifying providers and community resources as part of his/her back-up plan.
- Document the participant and his/her legal representative are evaluated for and instructed on how to recognize and report abuse, neglect and exploitation. The POT reflects any risk for abuse, neglect and exploitation and how incidents will be prevented.
- Ensure the written home safety evaluation has been completed and all identified issues are addressed on the POT. The home safety evaluation assesses participant accessibility, structural barriers, utilities, evacuation plans, and communication and fire safety systems and devices.
- Document the participant's home is safe.

Identified problems or deficiencies the POT are discussed with the waiver case manager, the participant, and/or his/her legal representatives and/or members of his/her circle of support. Corrections must be made to the POT, which is reviewed and approved by the participant's physician, before additional HCBS waiver services and/or continued enrollment in the NF/AH Waiver can be authorized by IHO. Health and safety issues described in the POT are documented using the Event/Issue Report and included in the participant's case record.

(c) On enrollment into the HCBS NF/AF Waiver, the intake CDHS/IHO NE reviews the initial POT with the participant and/or his/her legal representatives and/or circle of support. Ninety (90) days after waiver enrollment and the start of waiver services, the CDHS/IHO NE case manager conducts a home visit to assess how the participant is coping. The CDHS/IHO NE reviews the POT with

the participant and/or his/her legal representative(s) and/or circle of support to verify that services are provided as described. Subsequent scheduled LOC reevaluation visits include a review of the POT with the participant and/or his/her legal representative(s) and/or circle of support to determine if the POT continues to meet the participant's needs.

The level of case management acuity system is used by the CDHS/IHO NE to determine the frequency of home visits based upon the participant's risk factors and the complexity of his/her home program. The system identifies four levels of case management of increasing acuity. The level of acuity is reevaluated at each home visit and upon changes to the participant's medical care needs, support system, and provider types. The level of case management acuity system is described in detail in Appendix B, at item B-6(g)

Between the scheduled home visits, the CDHS/IHO NE maintains contact with the participant and the HCBS waiver case manager. A record of the interim contact is documented in the running record section of the participant's case record. Based on interim contact reports and/or information received from the participant or the waiver case manager, the CDHS/IHO NE may request the POT be updated to reflect changes in the participant's care needs, waiver providers, and/or the delivery of waiver services. The HCBS waiver case manager is responsible for submitting the revised POT to the CDHS/IHO NE for review and approval.

b. Monitoring Safeguards. *Select one:*

X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The procedure for informing Home and Community-Based Services (HCBS) Nursing Facility/Acute Hospital (HCBS NF/AH) Waiver participants and/or his/her legal representative(s) of the opportunity to request a fair hearing to appeal a State decision regarding waiver enrollment or waiver services is provided in two (2) pre-printed California Department of Health Services (CDHS) Notice of Action (NOA) letters. A NOA is sent to the participant or his/her legal representative when a request for enrollment in the waiver is denied, or when a HCBS service has not been approved as requested and is reduced, terminated, or denied by In-Home Operations (IHO).

The NOA for the denial of an initial request for enrollment in the NF/AH Waiver or for a HCBS waiver service is referred to as a Jackson v. Rank (JvR) letter. A decision regarding continuing waiver enrollment, a re-evaluation of a waiver participant's level of care (LOC), or the reduction, termination, or denial of previously authorized HCBS waiver service(s) require a NOA referred to as a Frank v. Kizer (FvK) letter. The CDHS/IHO Nurse Evaluator (NE) must mail the NOA to the participant and/or his/her legal representative(s), the ordering physician and the waiver service provider within 10 calendar days of adjudicating the request for waiver enrollment or a HCBS waiver service.

The NOA advises the participant of IHO's decision and the reason(s) to 1) terminate or deny waiver enrollment; 2) reduce or terminate previously authorized waiver services; or 3) deny new or previously authorized waiver services. The NOA includes

instructions advising the participant and/or his/her authorized representative(s) on how to request a State Fair Hearing before an Administrative Law Judge (ALJ). The participant must request a State Fair Hearing within 90 calendar days after the date the NOA was mailed to the participant.

The participant is advised that his/her waiver enrollment and/or previously authorized waiver services will continue without interruption, as long as the request for a State Fair Hearing is submitted to the California Department of Social Services, State Hearings Division prior to the expiration date printed at the top of the NOA or within ten (10) calendar days of the date of the notice, whichever is later. This is referred to as "aid paid pending". The participant and/or his/her legal representative(s) are responsible for submitting the request for a State Fair Hearing before the action takes place. A copy of the NOA is filed in the participant's case record maintained by the IHO nurse case manger.

State Plan and waiver services unaffected by the NOA will continue to be provided as authorized. The participant's Medi-Cal eligibility is not affected by a NOA, unless the NOA was issued because the participant no longer met the waiver requirements or LOC, or the participant obtained his/her
Medi-Cal eligibility through the waiver's income and resource eligibility requirements.

Upon request of a State Fair Hearing, IHO staff will contact the participant and/or his/her legal representative(s) to provide them with additional information on the State Fair Hearing process, and advise them they will receive the CDHS's written position statement before the scheduled hearing date. If the participant and/or his/her legal representative(s) have not identified legal representation, IHO will advise them of the process for requesting legal assistance. IHO will continue to work with the participant and/or his/her legal representative(s) to resolve the hearing issues before the fair hearing.

If the ALJ upholds IHO's decision to reduce, terminate, or deny continued enrollment in the waiver and/or a waiver service(s) any aid paid pending which the participant had been receiving will stop.

The participant can appeal the ALJ's decision by requesting a rehearing. Instructions on how to request the rehearing are included with the ALJ's written decision. To request a rehearing, the participant must mail a written request within 30 calendar days after receiving the decision. The participant must state the date the decision was received and the reason(s) why a rehearing should be granted. The participant can present additional evidence that could impact the original decision.

If the participant is unsatisfied with the outcome of the original hearing or rehearing, they can elect to seek a judicial review by filing a petition in Superior Court within one year of receiving the decision. The participant may file this petition without asking for

a rehearing. No filing fees are required and the participant may be entitled to reasonable attorney's fees and costs if the Court issues a final decision in his/her favor.

A waiver participant can request a fair hearing should any one of the following result in the denial, reduction, or termination of waiver services:

- The cost of the requested service(s) exceeds the cost of the identified institutional alternative and the participant and/or the primary caregiver does not agree to a reduction in the requested services in order to maintain program cost neutrality;
- The participant loses Medi-Cal eligibility;
- The participant moves from the geographical area in which the NF/AH Waiver services were being authorized to a new area where there are providers of services, but no provider has agreed to render waiver services to the participant;
- The participant's condition is unstable as demonstrated by repeated, unplanned hospitalizations;
- The participant's condition does not meet the medical eligibility criteria for the evaluated LOC described in the waiver;
- The participant or the primary caregiver refuses to comply with the primary care physician's orders on the Plan of Treatment (POT), and IHO determines that such compliance is necessary to assure the health, safety and welfare of the participant;
- The participant or the primary caregiver does not cooperate in attaining or maintaining the POT goals;
- The identified support network system or the primary caregiver cannot be identified, is not able, or is no longer willing or available to assume the responsibility to act as a back-up for the participant. The CDHS/IHO NE will work with the participant and responsible persons to develop a POT and identify providers so the participant can continue to reside safely in a home-like setting, when possible;
- The home evaluation, completed by the HCBS provider, documents an environment that does not support the participant's health, safety and welfare, or is otherwise not conducive to the provision of HCBS waiver services;
- The participant or the primary caregiver declines case management services when electing to receive the HCBS Personal Care benefit as the sole waiver service;
- The HCBS waiver service provider is unwilling or unable to provide the amount

of authorized services as required by the participant's POT and/or physician's order. This inability to provide services may impact the quality of the service(s) provided. Therefore, if requested to do so by the participant and/or the legal representative, the CDHS shall assist with the authorization process for the participant at the otherwise appropriate licensed health care facility, until another HCBS waiver service provider accepts the responsibility for providing services in the home setting;

- Any documented incidence of noncompliance by any party with the requirements of this agreement that poses a threat to the health or safety of the participant, and/or any failure to comply with all regulatory requirements;
- The participant and/or his/her legal representative(s) and/or circle of support are requesting direct care services that exceed 24 hours per day and do not agree to a reduction of services so as not to duplicate services;
- The participant receives 360 hours per month or greater of combined In Home Supportive Services (IHSS) Personal Care Services (PCS) and HCBSPC benefit services, and does not have two (2) or more personal care providers;
- The participant, legal representative, treating physician, or waiver service provider has not submitted to IHO a complete and current physician-signed POT within 180 days of the initial evaluation or within 60 days of the end-date of the previous POT; and
- IHO has not received a TAR or the HCBSPC benefit provider information within 180 days of the initial evaluation or within 60 days of the termination date of the last authorized waiver services.

In the event of a reduction or termination of waiver services and/or enrollment, the CHDS/IHO NE will assist the participant in identifying local community resources that may be available.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
X	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

○	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
X	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The California Department of Health Services (CDHS)/In-Home Operations (IHO) Nurse Evaluator (NE) is required to document all reported or observed critical events or issues that may affect the health, safety and welfare of waiver participants. Critical events or incidents are those reported or observed of participant abuse (physical/sexual) or neglect, incidents posing an imminent danger to the participant, fraud or exploitation (including misuse of participant's funds and/or property), or a dangerous physical environment. The CDHS/IHO NE provides instruction to the participant, his/her legal representative and/or members of his/her circle of support on how to report events or issues that affect or can affect the health, safety and welfare of the waiver participant.

The CDHS/IHO NE will use the Event/Issue Report form to document concerns or problems expressed by the participant, his/her legal representatives and/or circle of support to ensure timely investigation and resolution. In the case the event/issue is observed by a waiver provider and reported to the CDHS/IHO NE, the CDHS/IHO NE will document the waiver service provider's report in the participant's case record and complete an Event/Issue Report documenting the incident.

The Event/Issue Report form is designed to document:

- A description of the event or issue (the who, what, when and where);
- Who reported the event or issue;
- The State and local agencies, the treating physician, and law enforcement who were notified and when;
- The plan of action to address/resolve the event or issue (who, what, when); and
- The resolution and date resolved.

A copy of the completed Event/Issue Report form is maintained in the participant's case record and updated to document the resolution of the event/issue.

Incidents of possible abuse, neglect or exploitation require the CDHS/IHO NE to report the incident to the supervising CDHS/IHO NE and to the appropriate local or State agencies. The CDHS/IHO NE is responsible for documenting the referral in the participant's case record, including the agency and the name of the person(s) who received the referral and the person(s) responsible for conducting the investigation. Referrals are made to the following agencies:

- Adult Protective Services (APS);
- Child Protective Services (CPS); and
- Local law enforcement.

The Event/Issue Report form is used to communicate with the CDHS Licensing and Certification (L&C) on events/issues affecting participants that are related to home health agencies (HHA), adult day health care (ADHC) providers, pediatric day health care (PDHC) providers, congregate living health facilities (CLHF), and certified home health aides (CHHA). L&C will determine if the provider is in compliance with the California Health and Safety Code Sections 1736-1736.7 (HHA), 1575-1575.7 (ADHC), 1760-1761.8 and 1250(i). After consulting with the Supervising CDHS/IHO NE, the CDHS/IHO NE forwards the completed Event/Issue Report to L&C with a request that L&C investigate when there has been:

- Failure by the Medi-Cal provider to report abuse or neglect of a waiver participant. L&C will also notify the appropriate local or State agencies;
- Failure to notify the treating physician of a change in the participant's condition, if the participant is harmed by the failure of this action;
- Failure to inform the participant and/or his/her legal representatives of the participant's "Patient Rights", if the participant is harmed by the failure of this action;
- Failure to comply with the participant's "Patient Rights", if the patient is harmed by the failure of this action;
- Failure to complete the appropriate documentation and/or notify the participant's physician of an incident, if willful – an attempt to hide the action or error (i.e., medication or treatment error, fall);
- Failure to provide services or supplies as described on the POT, ordered by the physician and agreed to provide;
- Inadequate or inappropriate evaluation of the participant's needs (e.g., weight loss not assessed), if the participant is harmed by the failure of this

action;

- Inadequate notification to the participant when services or supplies are changed or terminated, if the patient is harmed by the failure of this action; and,
- Failure to act within a professional's scope of practice, if the participant is harmed by the failure of this action.

The participant's case record is updated to document the event/issue resolution and closure, and L&C actions and recommendations. During L&C's investigation, the CDHS/IHO NE will continue to work with the waiver providers, the participant's attending physician, the participant and/or his or her legal representative and/or circle of support to ensure that the participant receives needed services and can continue to reside safely in the home.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The CDHS/IHO NE is responsible for informing and discussing with the participant, his/her legal representatives, and/or members of his/her circle of support, how to identify and report issues of abuse, neglect or exploitation that impact the health, safety, and welfare of the participant. The CDHS/IHO NE discusses with the participant the different types of abuse, neglect, or exploitation and how to recognize if any of these occur and whom to contact to report such events/issues.

Each waiver participant, his/her attending physician and all Home and Community-Based Services (HCBS) waiver services providers receive the "HCBS Waiver Informing Notice" that includes a description of the roles and responsibilities of the participant, primary caregivers, attending physician, and the HCBS waiver services provider. It also includes information on how to notify the CDHS/IHO NE if there are any issues or concerns that may impact the safety, health, and welfare of the participant.

The CDHS/IHO NE evaluates the participant for issues of abuse, neglect, and exploitation during the initial face-to-face visit and at each reevaluation visit. The CDHS/IHO NE is required to provide the participant and/or his/her legal representative, his/her primary caregiver and members of the participant's circle of support with information on what constitutes abuse (physical, mental and

emotional), neglect, and exploitation, and how to report these issues. The CDHS/IHO NE documents these steps in the participant's case report as well as any actions taken.

If an event/issue is reported to, or observed by, the CDHS/IHO NE, the CDHS/IHO NE will document the incident using the Event/Issues Report form and update the participant's case record. Any issues regarding delivery of services which impact the health, safety and welfare of the participant are reported to the attending physician and, when necessary, to the appropriate local protective service agency, law enforcement and/or CDHS L&C.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When an event/issue is identified by, or reported to the CDHS/IHO NE, the CDHS/IHO NE will complete an Event/Issue Report form. The report is designed to document: who the report is from; the type of event or issue; the date and time of the event/issue, if applicable; the location of the incident (participant's home, etc.); details of the event; involved parties; the source of the information; individuals who have first-hand knowledge of the event; whether the attending physician was notified; and the name, address and phone number of the physician and any other agencies or individuals that were also notified. The specific nature of an event or issue will determine if notification of others is warranted, e.g., CPS, APS, California Children's Services, Regional Center, law enforcement, and/or CDHS L&C.

The CDHS/IHO NE will discuss the issues with the CDHS/IHO NE Supervisor and develop a plan of resolution. All plans developed to resolve identified problems are thoroughly evaluated by the CDHS/IHO NE Supervisor to ensure that they are appropriate, will result in a resolution which is amenable to the participant and/or his/her legal representative, and will ensure the participant's health, safety and welfare. All contact made by the CDHS/IHO NE with a HCBS provider of service, the attending physician, the participant and/or the legal representative related to the identified event/issue are clearly summarized and documented in the participant's case record by the CDHS/IHO NE. The CDHS/IHO NE will continue to follow-up with the HCBS provider(s) of service(s), the physician, the participant, and, if appropriate, the legal representative, for resolution. The CDHS/IHO NE will keep the participant and/or his/her legal representative informed of the progress of the investigation and will continue to follow-up until the issue is resolved. If the

issue is not resolved within 30 days, the CDHS/IHO NE will discuss the issue(s) with the CDHS/IHO NE supervisor and develop an alternative plan for resolution.

In the event a significant incident occurs, jeopardizing the health, safety and welfare of the participant while under the care of a HCBS waiver provider, the HCBS waiver provider shall submit written documentation to the CDHS/IHO NE for review. The HCBS waiver provider and/or the CDHS/IHO NE will act immediately on any report of incidents placing the waiver participant in immediate or imminent danger, including contacting local law enforcement when the event/issue is abuse, neglect, and/or exploitation. Within 24 hours of learning of or observing such events, the CDHS/IHO NE will complete an Event/Issue Report. When a determination has been made that other agencies or entities need to be involved in the response to, and resolution of, the event/issue, the CDHS/IHO NE, along with the HCBS waiver service provider, will contact the appropriate agency and provide the necessary information and documentation to assist in the investigation.

Events/issues referred to CDHS L&C are tracked to ensure that IHO can adequately respond to the reported findings and plan for resolution of the event/issue. The CDHS/IHO NE will follow up with the participant and/or legal representative to make sure the issue has been resolved and there is no longer any risk to the participant's health, safety and welfare.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The IHO Quality Assurance (QA) Unit is responsible for the oversight of event/issue reporting and response to critical incidents. Copies of completed event/issue report forms are maintained electronically for use in quality assurance monitoring. The IHO QA Unit tracks the use of the Event/Issue Report form, completeness of the form, documentation of the event/issue, entities contacted, implementation of the plan(s) of action, and resolution.

IHO's QA Unit conducts an annual quality management case record review to determine: (1) if the IHO staff are completing and submitting to the QA Unit the event/issue report for all events and issues that may or are affecting the participant's health and safety; (2) whether an appropriate action plan was developed and the outcome; and (3) whether systemic program issues exist that require remediation. The findings of the quality management case record review are documented in an annual report prepared by the QA Unit. Based upon the information in the annual report, IHO will develop action plans to address deficiencies in reporting and/or identified systemic issues.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed except for Item G-2-c-ii.

a. Applicability. *Select one:*

X	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(complete only Item G-2-c-ii)*
○	This Appendix applies. Check each that applies:
	☐ The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐ Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete item G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The CDHS/IHO NE is responsible for monitoring and ensuring the health, safety and welfare of waiver participants. This is accomplished through initial, scheduled, or unscheduled home visits by the CDHS/IHO NE and/or via telephone contact with participants, his/her legal representatives, IHO HCBS waiver providers, and attending physicians. If the IHO HCBS Waiver provider or the CDHS/IHO NE observes or learns that restrictive interventions are being used, an Event/Issue Report form must be completed. The CDHS/IHO NE must determine: 1) whether the use of restraints is ordered by the attending physician; 2) if a plan describing criteria for use and monitoring of restraints is documented in the participant's Plan of Treatment (POT); and 3) if the plan is being followed by the caregivers and/or providers.

If the CDHS/IHO NE determines that the attending physician has not authorized the use of restraints, or the use of the restraints is not in compliance with the POT, the appropriate law enforcement and either child or adult protective services be will contacted to report the event. Unauthorized use of restraints by a HHA, ADHC, PDHC and/or CLHF is referred to CDHS L&C to investigate and report on their findings. The CDHS/IHO NE is responsible for monitoring CDHS L&C's investigation and findings.

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
X	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

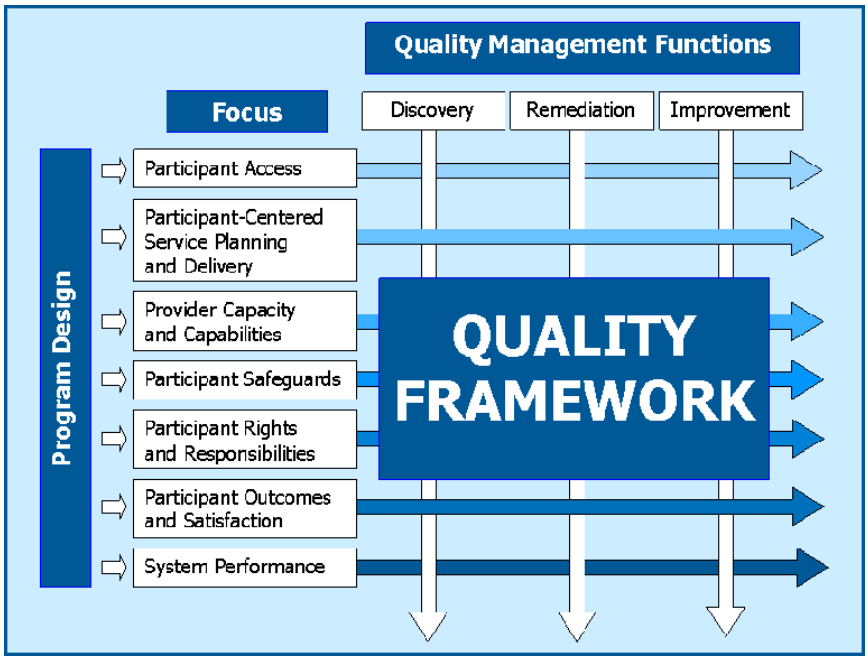
ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

State:	California
Effective Date:	January 1, 2007

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.

3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

In-Home Operations' (IHO) Quality Management Strategy is to develop and implement discovery tools and methods to evaluate California Department of Health Services (CDHS)/IHO's effectiveness in compliance with the waiver assurances and CDHS/IHO policies and procedures. As a result of discovery activities, CDHS/IHO will develop, implement, and evaluate remediation actions to enhance, correct, and/or improve CDHS/IHO's compliance. The CDHS/IHO Quality Management Unit (QMU) is responsible for developing discovery activities, collecting, and analyzing the data from the discovery activities. The staff of the QMU includes: a research analyst, waiver analysts, an eligibility analyst, an information system analyst, and licensed medical professionals. The CDHS/IHO Section Chief, Managers, Nurse Evaluator (NE) Supervisors, and QMU are responsible for the development, implementation, and evaluation of remediation actions. The QMU utilizes the following tools for discovery:

- Internet-based Case Management Information Systems (CMIS);
- Case Record Review;
- Provider Visit Review;
- Event/Issue database;
- California Medicaid Management Information System (CA-MMIS); and
- California Department of Developmental Services' Case Management Information Payrolling System (CMIPS).

The CMIS is a new database developed and implemented in 2005. During 2006, CDHS/IHO will begin using information from CMIS to establish new quality indicators that will help determine if changes need to be made to the waiver enrollment criteria, services, providers, or any other aspect of waiver administration. CMIS program can provide data on how potential participants are referred to the waiver, how many referrals are received, document the timeliness of the referral, evaluation, and enrollment process, captures data on applicants who are placed on the wait list, and track the reasons active waiver cases are closed. CMIS will also allow CDHS/IHO to document the utilization and cost of Home and Community-Based Services Personal Care (HCBSPC) benefit as well as track Notice of Action (NOA) and capture the number of requests for state hearings along with the outcomes of those hearings.

The QMU and the CDHS/IHO Medical Consultant, who is a licensed physician, are responsible for conducting the annual Case Record Reviews on active NF/AH Waiver cases. The selected sample size for the number of case records to be reviewed is determined by using the Sample Size Calculator located at http://www.surveysystem.com/sscalc.htm. The QMU will randomly select a sample of case records with a 95% level of confidence with a 5% interval for the entire waiver population. The waiver population includes all waiver participants that were open to the waiver anytime during the selected waiver year. Using the identified sample size indicated by the Sample Size Calculator, the QMU will select the cases for review based upon the corresponding percentage of participants at each level of care (LOC) by CDHS/IHO field office location and will ensure that all CDHS/ IHO NE staff are represented in the cases selected for review. The Case Record Review uses a Record Review Tool designed to document the following:

- Evidence of the accuracy of LOC evaluation;
- The participant, and/or his/her legal representative(s), and/or circle of support, which includes individuals identified by the participant, and their involvement in the development of the Plan of Treatment (POT);
- The POT appropriately addresses all of the participant's identified needs' and assures participant's health and welfare;
- The participant, and/or his/her legal representative(s), and circle of support's knowledge of issues concerning abuse, neglect, and exploitation and how to report them;
- The POT reflects that all the participant's services are planned and implemented in accordance with their unique needs, expressed preferences and decisions, personal goals, abilities, and health status in mind;
- Information and support is available to help the participant, and/or his/her legal representative(s) and/or circle of support to make selections among service options and providers;
- The design of the participant's home and community-based program is cost neutral;
- POT addresses the need for HCBS healthcare and other services; and
- The CDHS/IHO NEs level of compliance with CDHS/IHO's policies and procedures in the completion and maintenance of the waiver participant's case report.

The annual Case Record Review also uses the Record Review Tool to document compliance with the assurances provided in the NF/AH Waiver and CDHS/IHO's policies and procedures for annual provider visits conducted by the CDHS/IHO NEs.

The Provider Visit Review is conducted on each provider for those participants selected for the annual Case Record Review. The Provider Visit Overdue report is used to track annual provider visits that are 30 days overdue. The Provider Visit Review discovers if the CDHS/IHO staff conducts timely provider visits, ensures providers meet the waiver licensing and certification requirements, provides written feedback to the provider following a provider visit, notifies appropriate agencies of provider issues that effect the health and safety of the wavier participant, and documents that the provider has received HCBS waiver training.

CDHS/IHO Event/Issue database captures the type and number of events and issues that affect or can affect the health and safety of the waiver participant, the timeliness of the reporting, and the participant's and/or his/her legal representative(s), and circle of support's satisfaction with the outcome of the action plan for the reported issue or event. Reports are developed bi-annually and annually and evaluated for possible remediation actions.

The CA-MMIS and CMIPS databases are used to run utilization and expenditure reports to document that CDHS/IHO is meeting the waiver's cost assurances. CDHS/IHO annually submits a list of participants who were active on the waiver for the reporting year to the CDHS claims data-reporting contractor, Thomson/MedStat. Thomson/MedStat is responsible for running utilization and expenditure reports for waiver participants and peer groups and providing this data to the CDHS Medi-Cal Policy Division (MCPD), Waiver Analysis Section (WAS), and CDHS/IHO for analysis.

Using these tools, CDHS/IHO will be able to collect and analyze data for trends and patterns of populations served and make changes to policy, procedures, and resources based on that analysis. This information will be used to plan for future outreach activities. CDHS/IHO can then develop any needed remedial actions deemed necessary to provide the best service to the HCBS waiver population while assuring compliance with waiver assurances as well as CDHS/IHO polices and procedures.

H.1.a: Level of Care (LOC) Determination

LOC determinations are conducted for all applicants and enrolled participants utilizing the tools, procedures, and processes described in Appendix B-6. The QMU utilizes the CMIS and the Case Record Review to monitor the timeliness and accuracy of the LOC initial and re-evaluations determinations. The CMIS captures the data documenting:

- CDHS/IHO *received* the HCBS Questionnaire;
- CDHS/IHO *reviewed* the HCBS Questionnaire;

- The applicant was referred to the IHO Intake Unit for an initial visit and evaluation;
- The applicant was enrolled in the NF/AH Waiver; and
- When the next re-evaluation visit is due, based upon the level of case management.

The annual Quality Assurance Case Record Review conducted by the QMU staff and the CDHS/IHO Medical Consultant evaluates the accuracy of the LOC determination based on the information documented in the participant's case report.

In 2006, the QMU will use CMIS to conduct discovery activities on 100% of case records to establish time frame standards for initiation of HCBS waiver services. The number of days between receipt and review of the HBCS Questionnaire, the number of days between review and assignment to the Intake Unit, and the number of days from assignment to the Intake Unit and the initial visit by the Intake Unit CDHS/IHO NE will be captured and analyzed. The data from 2006 will be presented to the CDHS/IHO management team in the first quarter of 2007 to be used to establish time frame standards for these activities. In the second quarter of 2007, a written policy and procedure document will be developed by the QMU, distributed to the Intake Unit by the Intake Supervisors along with training on the standards. The QMU will develop monthly reports monitoring the timeliness of these activities and provide quarterly analysis to the CDHS/IHO Section Chief and Managers beginning the third quarter of 2007. The CDHS/IHO Section Chief, Managers, and QMU will use these reports to develop remediation activities as needed. Results of the discovery and remediation activities will be reported in the Centers for Medicare & Medicaid Services (CMS) 373 Q report.

Initial LOC evaluations are conducted as described in Appendix B. The IHO Intake Unit is responsible for the initial LOC evaluation and determination. The IHO Intake Unit staff consists of registered nurses (RN), identified as CDHS/IHO NEs and their Supervisor who is also a RN. The CDHS/IHO NE must submit evidence of the evaluation visit and documentation of the LOC determination to the IHO Intake Supervisor for the applicant to be enrolled in the waiver. Only the IHO Intake Supervisor and the QMU has permissions to enter the enrollment information in CMIS. The CMIS has an edit that will not allow the applicant to be enrolled in the waiver unless the date of the evaluation visit has been entered. Enrollment is documented by entering the date the applicant was determined to be eligible for the waiver and their LOC is selected.

The QMU will run monthly reports identifying the home visit date, enrollment date and LOC determinations for all cases opened for that month. A quarterly and annual report and analyses will be provided to the CDHS/IHO Section Chief, Managers and

Supervisors, here after referred to, as CDHS/IHO Management Team. Based upon the report, remediation actions will be developed by the CDHS/IHO Management Team and QMU. The QMU and Supervisors will provide training to the CDHS/IHO NEs on the remediation activities. The QMU will conduct monthly follow-up discovery activities to determine the effectiveness of the remediation actions and ensure understandability and user-friendly assistance is available.

Re-evaluations of LOC determinations are conducted as described in Appendix B. The Case Management Units are responsible for conducting timely LOC re-evaluations. The Case Management Units consist of RNs, identified as CMs, and their Supervisors who are also RNs. QMU uses the CMIS to discover the timeliness of the reevaluation LOC determinations using the Home Visit Over Due Report. This report calculates the date of the next LOC re-evaluation based upon the date of the last LOC evaluation and the participant's level of case management. The QMU runs a monthly report that identifies participants who have not had their LOC re-evaluation completed within 30 days of the calculated date. These reports are provided to the CDHS/IHO Management Team for the development of remediation activities to ensure regular, systematic, and objective methods are used to monitor a participant's well being and health status. The QMU provides a quarterly and annual report and analysis of the timeliness of the re-evaluation visits to the CDHS/IHO Management Team. Remediation actions will be developed based upon the level of compliance. The QMU and Supervisors will provide training to CMs. The QMU will conduct monthly follow-up discovery activities to determine the effectiveness of the remediation actions.

The QMU and CDHS/IHO Medical Consultant conduct the annual Case Record Review on a sample of participants who were enrolled in the waiver during the reporting waiver year. The QMU uses the Sample Size Calculator as previously described to determine the number cases for review. The cases selected for review will reflect the percentage of cases for each LOC in the waiver, percentage of cases per CDHS/IHO field office and ensure cases from all CDHS/IHO NEs are represented. The CDHS/IHO NE use a case report form to document their observations, actions, and information obtained during the participant's initial and re-evaluation visit. The CDHS/IHO NE document the participant's medical care needs and the justification of the LOC determination in the case report and use the criteria and regulations cited in the waiver in making the LOC determinations. It is CDHS/IHO's policy that the Supervisor reviews all case reports. Once the Supervisor has determined the case report is complete and is in agreement with the LOC determination, the Supervisor signs and dates the case report. If the Supervisor and CDHS/IHO NE are not in agreement with the LOC determination, the case report is reviewed by the CDHS/IHO Medical Consultant. The CDHS/IHO Medical

Consultant's LOC determination is final and documented in the case report.

The annual Case Record Review is used to discover the CDHS/IHO NE level of compliance with completing the case report and if the LOC determinations are in compliance with the NF/AH waiver facility alternatives. Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, CDHS/IHO Medical Consultant, Supervisors, and QMU within 90 days to develop procedures to ensure participant safeguards. Effectiveness of the remediation actions will be monitored by the CDHS/IHO Medical Consultant and Supervisors and re-evaluated at the next year's annual Case Record Review.

H.1.b: Service Plan

During the annual Case Record Review, the QMU uses the Record Review Tool to discover if the participant has a service plan, hereafter referred to as the POT, which is current in accordance with the standards described in Appendix B-7.

At the annual Case Record Review, the case report is evaluated for documentation by the CDHS/IHO NE to show that:

- The participant and/or his/her legal representative(s) and/or their circle of support exercise a high degree of involvement in the identification, development, and management of services and supports that meets the participant's needs;
- The services are delivered as described in the POT;
- The POT is modified to meet changing circumstances;
- The participant and/or his/her legal representative(s), and/or circle of support was informed of all the services and provider types available, and,
- If the POT did not reflect the participant's needs or was not observed to be successful, what corrective actions were taken and the result of the actions.

The annual Case Record Review looks for evidence in the case record for:

- Freedom of Choice document signed by the participant and/or his/her legal representative(s) stating they were informed of the choice of receiving care in their home and community in lieu of facility care;
- Copies of Informing Notices sent to the participant and/or his/her legal representative(s), current provider(s) and the current physician overseeing the home program;

- Current Menu of Health Services (MOHS), which lists all waiver services and provider types and identifies the services and providers the participant or legal representative has selected; and
- All the services identified on the MOHS are described on the participant's POT.
- Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. The analysis will include an evaluation of the waiver's impact to the participant's health and welfare and identify any risks to the participant and how those risks will be managed. Based upon these findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions are measured during the following year's annual Case Record Review.

H.1.c: Qualified Providers

The annual Case Record Review, conducted by the QMU, uses the Record Review Tool to discover evidence in the case record that the waiver providers were licensed and/or certified at the start of service, continue to have a current and active license and/or certification, and that they initially and continue to meet the waiver provider requirements as described in Appendix C-3. The evidence includes copies of professional licenses, State and Medi-Cal certification, copies of current basic life support certification, and documentation of education and work experience as described in the NF/AH Waiver's Standards of Participation (SOP). The Record Review Tool is designed to determine if the provider received an annual visit by CDHS/IHO staff, if the participant's chart maintained by the provider is current, if the provider is rendering the care as described on the participant's POT, and if the CM has evaluated the provider for any training needs and actions rendered as a result of the evaluation.

The Record Review Tool is used to document evidence the HCBSPC benefit provider, who is a non-licensed/non-certified individual who initially and continues to meet the CDHS/IHO NF/AH Waiver personal care provider requirements. Evidence includes documentation for each provider of enrollment in the county's In-Home Supportive Services (IHSS) Personal Care Services program, and a copy of each provider's Driver's License, Social Security Card, and signature.

During the annual Case Record Review, the QMU runs a report from CMIS identifying all the participant's HCBS Waiver providers to ensure providers are available and have the skills, competencies, and qualifications to support the participant effectively. This report is used to discover if the CDHS/IHO NE have obtained the required documentation for all of the participant's HCBS waiver providers.

Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions will be re-evaluated at the next year's annual Case Record Review.

In 2008, CDHS/IHO will begin development of a Provider Satisfaction Survey. The survey is a mechanism to secure feedback from providers, to evaluate the provider's satisfaction of being a NF/AH Waiver provider, the effectiveness of the NF/AH Waiver services in supporting the participant's choice to receive care in his/her home and community in lieu of care in a facility, and solicit suggestions for improving the NF/AH Waiver and/or processes. The goal will be to conduct a survey in 2009.

The timeline for this action is as follows:

- 1/1/08 - 4/30/08 - Conduct research on the Provider Satisfaction Surveys and select a model.
- 5/1/08 - 7/31/08 - Develop a survey, instructions and evaluation criteria. Have the appropriate Branch managers review and approve the survey and instructions.
- 8/1/08 - 10/30/08 - Ask a small sample number of providers to review the survey and provide feedback.
- 11/1/08 - 12/31/08 - Make changes to the survey and instructions based upon the provider's feedback.
- 2/1/09 - 3/15/09 - Issue and collect the survey by mail with possible follow-up by CDHS/IHO NE staff to help ensure a reasonable percentage of input by providers.
- 3/16/09 - 4/30/09 - Analyze and evaluate the results of the survey by provider type and present recommendations to CDHS/IHO Management Team. Provide results and recommendations to the providers and solicit their input.
- 5/1/09 - Develop and implement a remediation plan based upon all input. Determine frequency of future Provider Satisfaction Surveys.

H.1.d: Health and Safety

CDHS/IHO's staff is responsible for completion of an Event/Issue Report when they either discover or receive information of an event or issue that affects or can affect the health and safety of a participant. The Event/Issue Reports are sent to the QMU. The following information is entered into the Event/Issue Database:

- Date the event/issue was discovered or reported;
- Date the event/issue occurred;

- Type of event/issues (i.e. staffing, medication, equipment, abuse, neglect, exploitation);
- Date the event/issue was resolved; and
- Participant, legal representative, and/or circle of support 's satisfaction with the outcome.

The data is analyzed and monitored for ongoing concerns of affected participants, documentation of the interventions, timeliness of the actions, and participant, legal representative, and/or circle of support's satisfaction. The results of the analysis are presented semi-annually, annually or as needed to the CDHS/IHO Management Team. The CDHS/IHO Management Team will determine what changes in training, education, policies and/or procedures need to be made to protect the health and safety of the waiver's participants. Evidence of the effectiveness of the changes will be discovered through the annual Case Record Review.

The annual Case Record Review conducted by the QMU uses the Record Review Tool to document the evidence in the case record and the Provider Visit Report of the CDHS/IHO NEs evaluation of the participant's health and safety. The case record and Provider Visit Report prompt the CDHS/IHO NE to interview the participant, legal representative, and/or circle of support about any occurrence of unscheduled hospitalizations, emergency room visits, issues with medications, or any situation that could endanger the participant and document the outcome of these events. The annual Case Record Review looks for evidence that the CDHS/IHO NE have documented their observations of any issues concerning the participant's health care needs such as the need for medications to be managed efficiently and appropriately and notes that safeguards are in place to protect the participant from life endangering situations or conditions of abuse, neglect and/or exploitation. The annual report identifies risk factors and monitors the completion and submission to the QMU of an Event/Issue Report when issues concerning health and safety are identified in the case record or Provider Visit Report so modifications can be offered to promote participant independence and safety.

Within 90 days of the review, the QMU will present an analysis of the findings from the Case Record Review to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions will be re-evaluated at the next annual Case Record Review to assess health risk and safety safeguards.

In 2007, CDHS/IHO will begin development of a Participant Satisfaction Survey. The goal is to improve access to services and reduce unmet needs while allowing more person centered participation. The survey will allow the participant and/or legal

representative to provide feedback to CDHS/IHO anonymously on his/her satisfaction with the services and providers available through the waiver, identify issues that effect their health and safety, inform CDHS/IHO of his/her satisfaction or dissatisfaction with the CDHS/IHO staff, and solicit suggestions for improving the waiver and/or processes. The goal will be to conduct a survey in 2008.

The timeline for this action is as follows:

- 1/1/07 - 4/30/07 – Conduct research on the Participant Satisfaction Surveys and select a model.
- 5/1/07 - 7/31/07 – Develop a survey, instructions and evaluation criteria. Test the survey readability and have it reviewed and approved by the appropriate CDHS/IHO Management Team.
- 8/1/07 - 10/30/07 – Ask a small sample number of participants and legal representatives to review the survey and provide feedback.
- 11/1/07 – 12/31/07 - Make changes to the survey and instructions based upon the participants and legal representatives' feedback. Develop a policy and procedures to ensure anonymity of participant.
- 2/1/08 – 3/15/08 – Conduct survey and compile responses.
- 3/16/08 – 4/30/08 – Analyze and evaluate the results of the survey regarding the level of participant satisfaction in how the waiver is administered. Present recommendations to CDHS/IHO Management Team. Provide results and recommendations to the participants and solicit their input.
- 5/1/08 – Develop and implement a remediation plan based upon all input. Determine frequency of future participant surveys.

H.1.e: Administrative Authority

CDHS/IHO has sole responsibly for the administration and oversight of who is eligible for the NF/AH Waiver, the effectiveness of the participant's POT, the authorization of waiver services, the enrollment of waiver providers, and the monitoring of the participant's health and safety. The effectiveness of administration and oversight activities is discovered through the quality management strategy previously described in this Appendix.

The annual Case Record Review looks for evidence of issuance of a NOA to the participant or legal representative when the participant has lost Medi-Cal eligibility, CDHS/IHO has determined the participant no longer meets the waiver's LOC, there is a change in the participant's LOC resulting in a reduction in waiver services, or the participant does not meet the enrollment requirements as described in this waiver. The NOA provides the participant and legal representative with information as to their right to appeal CDHS/IHO's decision.

CDHS/IHO has developed a database that tracks State Fair Hearing requests, the basis of the hearing, and the outcome. The QMU will annually perform an analysis of the data. The analysis will look for trends and outcomes of the hearings that may indicate a need for changes within program policy and procedures. The information will be presented to the CDHS/IHO Management Team. Based upon the need, remediation actions will be developed and implemented by the QMU and Supervisors. Effectiveness of the remediation actions will be re-evaluated at the next Annual Review.

H.1.f: Financial Accountability

The QMU currently conducts ad hoc discovery activities based upon a provider's complaint of non-payment and the suspicion of fraud. The QMU will access either the Surveillance or Utilization Review Subsystem (SURS) or the CMIPS to obtain evidence that a claim was submitted by an NF/AH waiver provider for prior authorization of NF/AH Waiver services and was reimbursed at the established rate for the service. The evidence is submitted to the CDHS/IHO Management Team to determine what, if any, further action maybe required. For issues concerning fraud, the QMU will notify the CDHS's Audit and Investigations (A&I) Branch. For issues concerning non-payment for all but wavier personal care services, the QMU, CDHS/IHO NE, Supervisors or Managers will assist the provider in resolving the issues concerning the authorization of services. For issues beyond CDHS/IHO's ability to remedy, the provider will be referred to the Electronic Data System (EDS) Help Desk, and/or CDHS's Med-Cal Payment Systems Division. For non-payment of CDHS/IHO authorized HCBSPC benefit services, the provider will be referred to the Department of Social Services' IHSS program.

In 2007, CDHS/IHO will begin development of a Claims Quality Management strategy for reviewing NF/AH Waiver claims. The quality management strategy will include the following elements:

- Determining the sample size of claims to be reviewed;
- Establish processes for accessing the claims data in SURS and CMIPS;
- Determine if the provider submitting the claim is a qualified NF/AH Waiver provider.
- Determine if the reimbursement rate matches the established rate for the service, as noted in the Medi-Cal Provider Manual or CMIPS; and
- Determine if the services were prior authorized in:
  - CA-MMIS,
  - Service Utilization Review Guidance and Evaluation (SURGE), or
  - CMIPS

The QMU will conduct the review annually and provide the CDHS/IHO Management Team with the results within 90 days of the completion of the review. Based upon the results and the level of compliance, the CDHS/IHO Managers and Supervisors will develop and implement remediation activities within 90 days. Effectiveness of the remediation actions will be measured at the next year's annual review.

The timeline for this action is as follows:

- 1/1/07-3/31/07 – Conduct research on other claims discovery processes.
- 4/1/07-6/30/07 – Develop a Claims Review Tool. Conduct a test of the review tool to determine if the tool captures the information needed to determine if the claims are paid accurately and to an approved HCBS Waiver provider.
- 7/1/07-9/30/07 – Make changes to the Claims Review Tool based upon the test.
- Determine the average number of NF/AH Waiver claims processed over 2 years and determine a sample size of claims to be reviewed.
- 10/1/07-10/30/07 - Conduct a review on the representative sample of claims.
- 11/1/07-12/15/07 – Complete an analysis of the review and present recommendations to the CDHS/IHO Management Team.
- 1/2/08 – 3/1/08 – Develop and implement remediation actions as needed based upon the results of the review.
- 9/2008 – Implement the annual Claims Review.

H2: Roles and Responsibilities

The QMU is responsible for the measurement of performance, providing analysis when performance falls below the established Levels of Compliance, as described below, and the presentation of recommendations for remediation and improvement to CDHS/IHO's Management Team. In evaluating performance that falls below the established standards, the QMU will determine the cause of the problem or lack of documentation through interviews with the CDHS/IHO NE who are responsible for evaluating the participant's LOC, overseeing the POT to ensure it meets the participant's medical care needs, reporting issues that affect the health and safety of the participants, and ensuring the waiver providers meet the NF/AH Waiver's requirement. The Supervisors are also interviewed, as they are responsible for approving the LOC determinations and evaluating the documentation on the Case Report and Provider Visit Reports for completeness. The results of the interviews will be provided to the CDHS/IHO Management Team for the development of remedial actions. Based upon the need, remediation actions will be developed and implemented by the QMU and Management Team.

The QMU Nurse Consultant conducts weekly meetings to review State Fair Hearings requests that have been filed. The purpose of the meeting is to discuss the cases to ensure all efforts have been made to resolve the issue prior to going to the hearing, to ensure the participant and/or legal representative are aware of the fair hearing process and their rights, and review any decisions rendered by the Administrative Law Judge (ALJ) at previous hearings. Attendees include the QMU Nurse Consultant, the CDHS/IHO Medical Consultant, Nursing Supervisors, and the CDHS/IHO NE who will be representing the CDHS at the State Fair Hearing. Lessons learned are shared with staff at the weekly CDHS/IHO Managers and Supervisors meeting and the weekly CDHS/IHO NE meetings. Information from these meetings can lead to process and procedure changes and/or updates to CDHS/IHO policies.

The Managers and Supervisors are responsible for conducting CDHS/IHO NE staff meetings. These meetings occur weekly or bi-monthly depending on workload. The purpose of these meeting is to share information and provide training to the CDHS/IHO NEs. Some of the topics include: new or updated policies and procedures, a discussion of issues that affect the health and safety of waiver participants, presentation of case studies, new CMS and CDHS policies, legislation that can affect the waiver or our participants, and results of QMU activities.

CDHS/IHO conducts annual statewide meetings, as the budget permits, to provide training and updates to all CDHS/IHO staff. Based on areas of need identified by QMU reviews and requests by CDHS/IHO staff, CDHS/IHO locates speakers, identified by CDHS as leaders in their field of expertise, to provide training during these meetings. These training sessions could include such varied subjects as dealing with provider billing issues, elder and dependent abuse in the home setting, or communication issues. Evaluations are collected to determine if the training goals and objectives have been met. The meeting's minutes will also be reviewed annually by the QMU and a summary of identified issues, remedial actions and follow-up activities will be described in the annual CMS 373 Q report.

The QMU works with Thomson/MedStat, CDHS contractor for cost reports. The QMU provides Thomson/MedStat with the participant's identification number and service identifiers for cost reports for HCBS and State Plan services. Thomson/MedStat will also run cost reports on Medi-Cal beneficiaries who are receiving long term care in a NF/AH Waiver's facility alternative. The results of these reports are analyzed by the QMU for trends and patterns across populations and reported to CDHS/IHO Section Chief, Managers, Supervisors and the Medi-Cal Policy Division, Waiver Analysis Section. Evidence of remedial actions will be described in the annual CMS 373 Q report.

H3: Process to Establish Priorities and Develop Strategies for Remediation and Improvement

The CDHS/IHO Management Team is responsible for establishing priorities, remediation, and improvement actions. CDHS/IHO has established the following Levels of Compliance that are used to determine when remediation and improvement actions will occur. These levels of compliance are applied to the reports and reviews described in H1.

Levels of Compliance	
80-100%	Substantial compliance with NF/AH Waiver assurances and/or CDHS/IHO Policy & Procedures. No significant remediation actions required.
70-80%	Compliant with NF/AH Waiver assurances and/or CDHS/IHO Policy & Procedures, but raises concerns, additional investigation is needed. Remediation action and follow-up focus review as needed.
60-70%	Marginally compliant with NF/AH Waiver assurances and/or CDHS/IHO Policy & Procedures, remediation action and follow-up focus review required.
Less than 60%	Non-compliant with NF/AH Waiver assurance and/or CDHS/IHO Policy & Procedures, remediation action and follow-up focus review is required.

Regardless of the level of compliance, program issues that affect the immediate health and safety of the participants will receive priority. The issue will be brought to the attention of the Management Team and a remediation plan will be developed and implemented. The remediation plan may include contacting other agencies and State Departments for assistance, changes to CDHS/IHO's policies and procedures and/or requesting assistance from the CMS.

The Level of Compliance score is used to determine the priority in the development and implantation of remediation activities. Level of Compliance scores of less than 60% will require immediate action. A remediation plan will be developed and implemented within 90 days. A follow-up focus review will be conducted 90 and 180 days after implantation of the remediation plan to determine the effectiveness of the plan. Results of the review will be presented to the Management Team for future planning.

Compliance scores of 60-70% will have the next priority and will also require a remediation plan and follow-up focus review. Areas with a compliance review of 70-80% will be further investigated and the CDHS/IHO Management Team will determine if there is a need for a remediation plan. When CDHS/IHO is unable to address all areas of concern, CDHS/IHO will give priority to areas that directly affect the waiver participant. Follow-up focus review will only be conducted on participant related issues. Effectiveness of remedial actions related to CDHS/IHO compliance with internal polices and procedures will be measured at the annual review. Results of all reviews will be presented to the Management Team for future planning.

H4: Compilation and Communication of Quality Management Strategy

CDHS/IHO's quality management reports are designed as Administrative Management Reports. The following identify the major reports, the topic, frequency, and the recipient(s) of the report.

Name of Report	Topic	Frequency	Recipient(s) of Report
Waiting List	List of applicants awaiting a slot on the NF/AH Waiver.	Monthly	CDHS/IHO Management
Waiver Summary	Number of participants enrolled in the waiver and number of applicants assigned to the IHO Intake Unit and being assessed for enrollment.	Monthly	CDHS/IHO Management
Intake greater than 6 months	List of applicants who have been assigned to the IHO Intake Unit for more than 6 months	Monthly	CDHS/IHO Management
Home Visit Overdue	List of participants whose re-evaluation visit is over due by 30 days or more	Monthly, Quarterly Annually	Supervisors, CDHS/IHO Management

Provider Visit Overdue	Annual Provider visit is overdue by 30 days or more	Monthly, Quarterly Annually	Supervisors, CDHS/IHO Management
Event/Issue Report	By issue, amount of time to resolve, and participant satisfaction	Bi-annual Annually	CDHS/IHO Management
State Fair Hearing Report	By issue and outcomes	Annually	CDHS/IHO Management
Outreach Activities	List of outreach activities, who attended, and average evaluation scores.	Annually	CDHS/IHO Management

In 2008, CDHS/IHO will evaluate the ability to post the results and remediation actions from the Annual Case Record and Provider Visits Reviews on the CDHS website. In 2009, CDHS/IHO will have the ability to post the results and remediation actions from the Participant and Provider Surveys on the website.

H5: Periodic Evaluation and Revision of Quality Management Strategy

The QMU and participants of the Case Record and Provider Visit Review conduct a post-review evaluation of the review process and evaluation tools. Based upon the evaluation, the Case Record, Provider Visit Review Tools and instructions may be revised to remove items that have a history of significant compliance and add new items which have been identified as a potential issue or problem, and modify policies and procedures for how a specific issue is reviewed. CDHS/IHO will conduct a post-review of the implementation of the Provider Satisfaction Survey in the third quarter of 2009, the Participant Satisfaction Survey in the fourth quarter of 2008 and the Claims Quality Management Strategy in the first quarter of 2008. Changes to any of the above processes will be described in the annual CMS 373 Q report.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In-Home Operations (IHO) Home and Community-Based Services (HCBS) Nursing Facility/Acute Hospital (NF/AH) Waiver providers are not subject to the requirement of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146). IHO does not grant federal or state awards to participating waiver providers.

Payments for most, but not all, NF/AH Waiver and State Plan services are made through the approved California Medi-Cal Management Information System (CA-MMIS). The California Department of Health Services (CDHS) Payment Systems Division (PSD) administers the Medi-Cal claiming system and manages the State's third party fiscal intermediary contract with Electronic Data Systems (EDS).

All claims processed through EDS are subject to random post adjudication, pre-payment verification for detection of errors, irregularities, and potential for waste, fraud, or abuse. Specific criteria for appropriate claims processing has been established and measurements against these criteria occur weekly before the release of payments.

The CDHS Audits and Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services, including the NF/AH Waiver program.

All claims submitted by waiver and State Plan providers are subject to random review regardless of provider type, specialty, or service rendered. A&I verifies that claims selected have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment. Failure to comply with the request for additional documentation may result in suspension from the Medi-Cal program, pursuant to Welfare and Institutions Code (W & I Code), Section 14124.2.

The A&I Division has three branches that conduct reviews using various methodologies to ensure program integrity and the validity of claims for reimbursement.

The A&I Medical Review Branch (MRB) performs essential medical reviews of non-institutional providers. Providers may also be subject to a more comprehensive review on a weekly basis known as a pre-checkwrite review. This review is based on a set of criteria, such as irregular billing patterns, designed to identify potential fraud or abuse. Providers selected for this more comprehensive review will receive an on-site visit by A&I staff. Many of these reviews result in program removal, monetary penalties, or less intrusive sanctions and utilization controls.

MRB also conducts Medi-Cal provider anti-fraud activities which include performing field reviews on new Medi-Cal providers and providers undergoing re-enrollment. MRB is charged with bringing closure to sanctioned providers through audits designed to quantify the abuse, settlement agreement, or permissive suspensions (exclusions) from the Medi-Cal program. Failure to comply with any request by A&I staff for documentation may result in administrative sanctions, including suspension from the Medi-Cal program, pursuant to W & I Code, Section 14124.2.

MRB staff work closely with EDS in data mining and extracting processes as well as the performance of the annual Medi-Cal Payment Error Study.

The A&I Financial Audits Branch performs cost settlement and rate setting audits of institutional providers, i.e. hospitals, nursing facilities, and certain clinics.

The A&I Investigations Branch (IB) conducts investigations of suspected Medi-Cal beneficiary fraud as well as preliminary investigations of provider fraud. IB is also responsible for coordinating provider fraud referrals to the State Department of Justice (SDOJ) and Federal Bureau of Investigation. Suspected fraud or abuse identified through any audit or investigation process is referred to the SDOJ via the IB.

IB and MRB coordinate the placing of administrative sanctions on providers with substantiated evidence of fraud. IB serves as CDHS' principal liaison with outside law enforcement and prosecutorial entities on Medi-Cal fraud.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Medi-Cal Policy Division, Rate Development Branch (RDB) establishes the provider payment schedule for Medi-Cal services, conducts rate studies, develops and implements systems to track and constrain the growth of Medi-Cal rates, and responds to rate-related inquiries from providers, associations, and other interested parties. The RDB formulates reimbursement methodologies for fee-for-service outpatient services, and conducts annual rate studies for long-term care providers, which include nursing facilities and home health agencies.

Methodologies for establishing reimbursement rates for Medi-Cal services are described in state statute. Factors considered when establishing or revising provider rates include:

- For non-physician services, RDB surveys the federal Medicare Part B program to assure that the Medi-Cal rates of reimbursement do not exceed the lowest maximum allowance for the same Medi-Cal State Plan service;
- Review of standards of care prescribed under state statutes and regulations and identification of service providers;
- Identification of cost factors;
- Identification of at least seven states offering a similar type of service, and determining the average rate of reimbursement; and
- Market survey and identification of rates of reimbursement by governmental and non-governmental third-party payers for the same or similar services.

Changes in the amount the State reimburses for Medi-Cal State Plan and waiver services rates are authorized by the State's Legislature, and approved and implemented by the Governor.

IHO uses four methods to establish rates for NF/AH Waiver services, which are based on provider type and the service provided:

1. The adoption of published Medi-Cal State Plan or other State Department service rates for similar services;
2. Hourly rates established locally by county governments/authorities;
3. Annual rate studies; and
4. By report for prior authorized services, with minimum and maximum levels of payment described in the service description of Appendix C-2, General Services Specifications.

(Continued on next page)

The table below describes the rate methodology used to establish payment rates for IHO NF/AH Waiver services.

Rate Methodology	HCBS Service
Adoption of published service rates for similar State Plan services	• Case Management • Transitional Case Management • Waiver Service Coordination • Family Training • Habilitative Services • Private Duty Nursing, HCBS Provider • Respite
Hourly rates established locally by county government/authorities	HCBS Personal Care (HCBSPC) Benefit
Annual rate studies	• Respite, inpatient nursing facility • Private Duty Nursing - Home Health Agency • Private Duty Nursing - HCBS Nursing Facility
By report for prior authorized services	• Community Transition Services • Environmental Accessibility Adaptations • Personal Emergency Response (PERS) (activation and monthly service charge) • Medical Equipment Operating Expense

Rates paid for NF/AH Waiver services are published in the Medi-Cal Provider Manual and notices of updates are sent to Medi-Cal providers by U.S. mail or by e-mail notices.

IHO provides information regarding the payment rates for waiver services to the waiver participants through the use of the Menu of Health Services (MOHS). The MOHS lists available waiver services, eligible providers, and the cost of services, by provider type. Each waiver participant is provided a copy of the MOHS at the initial visit and at each reevaluation visit.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

IHO is responsible for prior authorization of all NF/AH Waiver services and verifies that the requested services are in accordance with the participant's Plan of Treatment (POT). NF/AH Waiver service providers are responsible for submitting a Treatment Authorization Request (TAR) to IHO for prior authorization of all NF/AH Waiver services except the HCBSPC benefit. The CDHS/IHO Nurse Evaluator (NE) reviews the TAR for medical necessity and to ensure services are authorized in accordance with the participant's POT. Claims for services are paid after the service is rendered.

CDHS PSD has overall responsibility for ensuring payment of Medi-Cal claims for authorized services. PSD oversees the contract with EDS, the state's Medi-Cal fiscal intermediary responsible for managing the Centers for Medicare & Medicaid Services (CMS) approved CA-MMIS.

NF/AH Waiver providers submit claims to EDS for services rendered using either a CMS 1500 or UB 92 claim form. These claims are subject to all established requirements for processing directly through the CA-MMIS system. EDS adjudicates claims for services, resulting in one of four possible actions:

1. Paid (claim is paid);
2. Denied (claim is denied);
3. Suspended (EDS staff perform further research); or
4. Additional information is requested (a Resubmission Transmittal Document (RTD) is sent to the provider requesting additional information).

Claims passing all edits and audits are adjudicated daily. EDS forwards a payment tape weekly to the State Controller's office for a checkwrite and the provider is notified through a Remittance Advice Detail form.

HCBSPC benefit claims are paid through the Department of Social Services (DSS), In-Home Supportive Services (IHSS), Case Management Information Payrolling System (CMIPS), which is developed and managed by EDS.

The CDHS/IHO NE authorizes HCBSPC benefit service hours by completing a written letter of authorization that is forwarded to the waiver participant, the HCBSPC benefit provider, and the IHO staff responsible for time cards and payment authorizations. Time cards are mailed to HCBSPC benefit providers with instructions on how to report the HCBSPC benefit hours provided to the waiver

participant.

HCBSPC benefit providers submit monthly timesheets signed by the waiver participant or his/her legal representative to the IHO Northern Region office for review and approval. The timesheets are reconciled with the hours authorized in accordance with the waiver participant's POT. IHO staff access the HCBS benefit section of CMIPS to authorize payment for claimed hours of service, documenting the hours worked, the rate of payment, and the gross amount approved for payment. The CMIPS system generates a payment tape daily that is sent to the State Controller's office where a payroll warrant is issued to the provider.

c. Certifying Public Expenditures *(select one)*:

○		**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid:
	☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
X		**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved POT; and, (c) the services were provided:

IHO is responsible for prior authorization of all NF/AH Waiver services and verification that the requested services are in accordance with the participant's POT.

Claims for waiver services must meet either the CA-MMIS or CMIPS requirements for processing, including program edits and audits. Submitted claims are reviewed to ensure that all required information is present.

Completed claims processed through CA-MMIS are run against system edits and audits to verify:

- Services are prior authorized;
- Participant is a Medi-Cal beneficiary and is enrolled in the NF/AH Waiver;
- Satisfactory Medi-Cal eligibility status;
- Provider is an enrolled Medi-Cal HCBS Waiver provider;
- Claim is not a duplicate;
- Claim is paid per the published rates or IHO negotiated rate;
- Participant was not institutionalized during the time covered by the claim; and
- Appropriate NF/AH Waiver procedure codes.

Completed HCBSPC benefit claims processed through CMIPS are run against system edits and audits to verify:

- Services are prior authorized;
- Participant is authorized to receive services through IHSS and is enrolled in the NF/AH Waiver program;
- Provider is enrolled as an IHSS provider authorized to provide services to the NF/AH Waiver participant;
- Claim is not a duplicate;
- Claim does not exceed maximum authorized hours; and
- Participant was not institutionalized during the time covered by the claim.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

○	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
X	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
	(a) The HCBSPC waiver benefit is not paid through the CA-MMIS. (b) HCBSPC benefit provider time sheets are sent to the IHO Northern Regional office in Sacramento. IHO staff verifies eligibility for HCBSPC benefit services, the county pay rate, and check the hours submitted for payment against hours authorized. IHO staff then calculates a payment amount due to the provider and enters the authorization number and payment information into the HCBSPC benefit segment of CMIPS. (c) DSS, through an Interagency agreement, provides payment to the HCBSPC benefit providers through CMIPS, a system developed by EDS for use by DSS in processing claims for providers enrolled in the IHSS program. CMIPS captures service evaluation information, issues Notices of Action (NOA), interfaces with the Medi-Cal Eligibility Data System (MEDS), generates management utilization and expenditure reports, and captures claim payment history. The CMIPS system generates a payment tape daily that is sent to the Office of the State Controller where a warrant is issued to the provider. (d) CDHS reimburses DSS for making payments for the authorized HCBSPC benefit hours under the NF/AH Waiver. DSS provides CDHS data tapes for reconciliation of payments for HCBSPC benefit services. The accuracy and timeliness of payments to HCBSPC benefit providers are monitored through CMIPS.

○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements:

X	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
X	**No**. Public providers do not receive payment for waiver services. *Do not complete ItemI-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

X	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that are paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
X	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
X	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
X	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

X	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
X	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co- Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care:			Nursing Facility A/B, Subacute, and Hospital				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference** (Col. 7 less Col. 4)
WY 1							
NF A/B	$21,561	$25,867	$47,428	$42,014	$5,276	$47,290	($138)
NF SA	$95,353	$54,538	$149,891	$199,416	$13,721	$213,138	$63,247
Hospital	$165,749	$29,742	$195,491	$337,729	$20,082	$357,811	$162,320
Weighted	**$68,990**	**$36,314**	**$105,303**	**$131,094**	**$9,933**	**$141,027**	**$35,724**
WY 2							
NF A/B	$21,988	$26,384	$48,372	$46,480	$5,381	$48,235	($136)
NF SA	$97,259	$55,629	$152,888	$203,405	$13,996	$217,400	$64,513
Hospital	$169,063	$30,337	$199,399	$344,484	$20,484	$364,967	$165,568
Weighted	**$69,156**	**$36,952**	**$106,108**	**$131,353**	**$10,012**	**$141,365**	**$35,257**
WY 3							
NF A/B	$22,423	$26,912	$49,335	$43,711	$5,489	$49,200	($134)
NF SA	$99,204	$56,741	$155,945	$207,473	$14,275	$221,748	$65,803
Hospital	$172,416	$30,944	$203,360	$351,373	$20,893	$372,267	$168,907
Weighted	**$69,569**	**$37,611**	**$107,180**	**$131,835**	**$10,103**	**$141,938**	**$34,758**
WY 4							
NF A/B	$22,867	$27,450	$50,317	$44,586	$5,598	$50,184	($133)
NF SA	$101,185	$57,876	$159,061	$211,622	$14,561	$226,183	$67,122
Hospital	$175,863	$31,562	$207,426	$358,401	$21,311	$379,712	$172,286
Weighted	**$70,059**	**$38,290**	**$108,349**	**$132,510**	**$10,206**	**$142,717**	**$34,367**
WY 5							
NF A/B	$23,319	$27,999	$51,318	$45,477	$5,710	$51,188	($131)
NF SA	$103,207	$59,034	$162,240	$215,855	$14,852	$230,707	$68,467
Hospital	$179,380	$32,194	$211,573	$365,569	$21,737	$387,306	$175,733
Weighted	**$70,631**	**$38,989**	**$109,620**	**$133,358**	**$10,319**	**$143,678**	**$34,058**

Nursing Facility A/B Levels of Care							
Waiver Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Col. 7 less Col. 4)**
Facility Type:			**Nursing Facility A**				
WY 1	$19,201	$15,365	$34,566	$27,197	$8,719	$35,916	$1,350
WY 2	$19,582	$15,672	$35,254	$27,741	$8,893	$36,634	$1,380
WY 3	$19,970	$15,986	$35,956	$28,296	$9,071	$37,367	$1,411
WY 4	$20,367	$16,305	$36,672	$28,862	$9,252	$38,114	$1,442
WY 5	$20,771	$16,631	$37,403	$29,439	$9,437	$38,876	$1,474
Facility Type:			**Nursing Facility B**				
WY 1	$22,259	$24,082	$46,341	$36,597	$5,258	$41,855	($4,486)
WY 2	$22,699	$24,564	$47,263	$37,329	$5,363	$42,692	($4,571)
WY 3	$23,148	$25,055	$48,203	$38,076	$5,470	$43,546	($4,657)
WY 4	$23,606	$25,556	$49,162	$38,838	$5,579	$44,417	($4,746)
WY 5	$24,074	$26,067	$50,141	$39,615	$5,691	$45,306	($4,836)
Facility Type:			**Nursing Facility B, Distinct Part**				
WY 1	$29,974	$45,509	$75,483	$75,306	$7,878	$83,184	$7,701
WY 2	$30,570	$46,419	$76,989	$76,812	$8,036	$84,848	$7,859
WY 3	$31,177	$47,347	$78,525	$78,348	$8,197	$86,545	$8,020
WY 4	$31,797	$48,294	$80,091	$79,915	$8,361	$88,276	$8,184
WY 5	$32,429	$49,260	$81,689	$81,513	$8,528	$90,041	$8,352
Facility Type:			**Nursing Facility B, Pediatric**				
WY 1	$13,466	$41,089	$54,555	$90,274	$4,102	$94,376	$39,821
WY 2	$13,734	$41,911	$55,645	$92,079	$4,184	$96,263	$40,619
WY 3	$14,008	$42,749	$56,757	$93,615	$4,268	$97,883	$41,432
WY 4	$14,287	$43,604	$57,890	$95,487	$4,353	$99,840	$42,262
WY 5	$14,571	$44,476	$59,047	$97,397	$4,440	$101,837	$43,109

Nursing Facility Subacute Levels of Care							
Waiver Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Col. 7 less Col. 4)**
Facility Type:			**Nursing Facility Subacute, Adult**				
WY 1	$134,082	$41,806	$175,888	$180,219	$10,667	$190,886	$14,998
WY 2	$136,764	$42,642	$179,406	$183,823	$10,880	$194,704	$15,298
WY 3	$139,499	$43,495	$182,994	$187,500	$11,098	$198,598	$15,604
WY 4	$142,286	$44,365	$186,650	$191,250	$11,320	$202,570	$15,919
WY 5	$145,130	$45,252	$190,382	$195,075	$11,546	$206,621	$16,239
Facility Type:			**Nursing Facility Subacute, Pediatric**				
WY 1	$13,052	$81,593	$94,645	$240,211	$20,211	$260,422	$165,777
WY 2	$13,311	$83,225	$96,536	$245,015	$20,615	$265,630	$169,094
WY 3	$13,576	$84,890	$98,465	$249,916	$21,027	$270,943	$172,478
WY 4	$13,846	$86,588	$100,433	$254,914	$21,448	$276,362	$175,929
WY 5	$14,121	$88,320	$102,440	$260,012	$21,877	$281,889	$179,449

Hospital Level of Care							
Waiver Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Col. 7 less Col. 4)**
Facility Type:			**Hospital**				
WY 1	$165,749	$29,742	$195,491	$337,729	$20,082	$357,811	$162,320
WY 2	$169,063	$30,337	$199,399	$344,484	$20,484	$364,967	$165,568
WY 3	$172,416	$30,944	$203,360	$351,373	$20,893	$372,267	$168,907
WY 4	$175,863	$31,562	$207,426	$358,401	$21,311	$379,712	$172,286
WY 5	$179,380	$32,194	$211,573	$365,569	$21,737	$387,306	$175,733

Appendix J-2 – Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care		
		Level of Care: **NF A/B**	Level of Care: **NF SA**	Level of Care: **Hospital**
Year 1	2595	1390	905	300
Year 2	2755	1500	955	300
Year 3	2915	1610	1005	300
Year 4 (renewal only)	3075	1720	1055	300
Year 5 (renewal only)	3235	1830	1105	300

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The calculated average length of stay (ALOS):

$$\textbf{ALOS} = \frac{\text{(Sum of days all participants enrolled calendar years 2003-2005 per IHO database)}}{\text{(Unduplicated count of waiver participants enrolled calendar 2003-2005 per IHO database)}}$$

Assumptions used in calculation:

- ALOS is a weighted average covering calendar years 2003, 2004, and 2005.
- ALOS is a weighted average of all participants enrolled in the NF A/B, NF SA, and IHMC waivers.
- Participants with a waiver Start of Service date on or before January 1st of the calendar year were selected for ALOS calculation.
- IHO waiver enrollment experience shows that participants enrolled in a waiver will maintain continuous enrollment until forced to leave due to illness or death.
- The ALOS is expected to remain constant each waiver year.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D utilization factors for existing waiver services are derived from experience as reported in the CMS 372 reports for the NFA/B, NF SA, and IHMC HCBS waivers. Assumptions used for projecting utilization of new waiver services are described below.

CMS 372 reports used:

- NF AB Waiver
  - WY 3 (January 1, 2003 – December 31, 2003)
  - WY 4 (January 1, 2004 – December 31, 2004)
- NF S/A Waiver
  - WY 2 (April 1, 2003 - March 31, 2004)
  - WY 3 (April 1, 2004 - March 31, 2005)
- IHMC Waiver
  - WY 1 (July 1, 2003 - June 30, 2004)
  - WY 2 (July 1, 2004 - June 30, 2005)

The following are assumptions used in deriving the Factor D:

- Utilization of Case Management Services is projected to be 100% for waiver participants. All waiver participants receive the constant monitoring and oversight provided through case management services.
- Waiver participants under 21 years of age receive waiver services when like services are not available through the State plan.
- Community Transition Services benefit is capped at a lifetime benefit of $5,000.00.
- Environmental Accessibility Adaptations benefit is capped at a lifetime benefit of $5,000.00.
- The Medical Equipment Operating Expense is limited to that portion of the utility bills directly attributable to operation of life sustaining medical equipment in the participant's place of residence. The minimum monthly amount of reimbursement will be $20.00 a month with a maximum monthly amount of $75.00. For purposes of completing Appendix J-d, an average of $25.00 is used based on reported utilization obtained from the CMS 372 reports.

- The cost of waiver services are projected to increase at two percent per year in accordance with the current California Consumer Price Index, provided the appropriate State of California funding authorities approve the increases.
- The average reimbursement rate for a waiver service is derived from averaging rates of reimbursement for the different providers providing a waiver service.
- The calculated Average Units per User values are based on the ALOS factor that reduces the anticipated annual utilization of a waiver service by 7%. The ALOS factor is 93% (341/365=93%).
- Average Units per User for Respite services, Environmental Accessibility Adaptations, Personal Emergency Response Systems (PERS) Installation/Activation, and Community Transition Services were not reduced by the ALOS factor, since these services either are one-time events or are used sporadically during the year.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D' estimates for State Plan services are derived from experience as reported in the CMS 372 reports for the NFA/B, NF SA, and IHMC HCBS waivers. Other assumptions used for obtaining the aggregate Factor D', and for each level of care (LOC) described in this waiver are described below.

CMS 372 reports used:

- NF AB Waiver
  - WY 3 (January 1, 2003 – December 31, 2003)
  - WY 4 (January 1, 2004 – December 31, 2004)
- NF S/A Waiver
  - WY 2 (April 1, 2003 - March 31, 2004)
  - WY 3 (April 1, 2004 - March 31, 2005)
- IHMC Waiver
  - WY 1 (July 1, 2003 - June 30, 2004)
  - WY 2 (July 1, 2004 - June 30, 2005)

The following are assumptions used in deriving the Factor D':

- The cost of all State Plan services furnished in addition to waiver services while the participant was on the waiver, including, but not limited to:
  - State Plan home health services;
  - State Plan personal care services authorized through the county's In

Home Supportive Services program;
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services;
- Adult day health care;
- Short-term institutionalization (hospitalization or Nursing Facility) which began after the participant's first day of waiver services and ended before the end of the waiver year, if the person returned to the waiver.
- Durable medical equipment covered under the State Plan;
- Medical supplies covered under the State Plan;
- Non-emergency transportation services covered under the State Plan; and
- Outpatient clinic and physician services covered under the State Plan.

- Factor D' is projected to increase at two percent per year in accordance with the current California Consumer Price Index, and the approval of the State of California funding authorities.
- Medicare Part D drug costs are not included in the Factor D' estimates.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G estimates for inpatient NF A/B, NF subacute, and hospital LOC are derived from experience as reported in the CMS 372 reports for the NFA/B, NF SA, and IHMC HCBS waivers. Other assumptions used for obtaining the aggregate Factor G, and for each level of care described in this waiver are described below.

CMS 372 reports used:

- NF AB Waiver
  - WY 3 (January 1, 2003 – December 31, 2003)
  - WY 4 (January 1, 2004 – December 31, 2004)
- NF S/A Waiver
  - WY 2 (April 1, 2003 - March 31, 2004)
  - WY 3 (April 1, 2004 - March 31, 2005)
- IHMC Waiver
  - WY 1 (July 1, 2003 - June 30, 2004)
  - WY 2 (July 1, 2004 - June 30, 2005)

The following assumption is used in deriving the Factor G:

The Factor G (inpatient costs) are projected to increase at two percent per year in accordance with the current California Consumer Price Index, provided the appropriate State of California funding authorities approve the increases.

Beginning January 1, 2007, the individual institutional cost limit is based on the approved Waiver Year 1 Factor G for each level of care described in Appendix B-2. Increases in the Medi-Cal institutional reimbursement rates paid may affect the individual institutional cost limit. Increases in the NF/AH waiver institutional cost limit will require the approval by the California Department of Finance and authorization of the State Legislature of appropriations to support an increase in waiver expenditures. CDHS will seek CMS approval to amend the NF/AH Waiver before implementation of any change to cost neutrality factors.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G' estimates for State Plan services utilization during an inpatient NF A/B, NF subacute, and hospital LOC from experience as reported in the CMS 372 reports for the NFA/B, NF SA, and IHMC HCBS waivers. Other assumptions used for obtaining the aggregate Factor G', and for each level of care described in this waiver are described below.

CMS 372 reports used:

- NF AB Waiver
  - WY 3 (January 1, 2003 – December 31, 2003)
  - WY 4 (January 1, 2004 – December 31, 2004)
- NF S/A Waiver
  - WY 2 (April 1, 2003 - March 31, 2004)
  - WY 3 (April 1, 2004 - March 31, 2005)
- IHMC Waiver
  - WY 1 (July 1, 2003 - June 30, 2004)
  - WY 2 (July 1, 2004 - June 30, 2005)

The following are assumptions used in deriving the Factor G':

- The cost of all State Plan services furnished during an inpatient stay.
- Factor G' is projected to increase at two percent per year in accordance with the current California Consumer Price Index, and the approval of the State of California funding authorities.
- Medicare Part D drug costs are not included in the Factor G' estimates.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Case Management	Hours	2596	27	$40.60	$2,822,756
Community Transition Services	Event	56	1	$5,000.00	$280,000
Environmental Accessibility Adaptations	Event	26	1	$5,000.00	$130,000
Family Training	Hours	62	14	$40.60	$36,296
Habilitation Services	Hours	20	389	$30.68	$238,474
HCBSPC Benefit	Hours	1604	1946	$12.02	$37,519,853
Medical Equipment Operating Expense	Months	105	9	$25.00	$24,525
Personal Emergency Response Systems	Months	14	9	$31.51	$3,970
Personal Emergency Response Systems, Activation/Installation	Event	14	1	$35.00	$490
Private Duty Nursing	Hours	1575	2891	$30.25	$137,742,620
Respite - Facility	Days	27	5	$313.57	$42,333
Respite - Home	Hours	95	40	$23.62	$89,745
Transitional Case Management	Hours	38	22	$40.60	$33,536
Waiver Services Coordination	Hours	47	33	$40.60	$63,783
GRAND TOTAL:					**$179,027,933**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					2,595
FACTOR D (Divide grand total by number of participants)					**$68,990**
AVERAGE LENGTH OF STAY ON THE WAIVER					341

Waiver Year: 2					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Case Management	Hours	2755	26	$41.41	$3,022,041
Community Transition Services	Event	58	1	$5,000.00	$290,000
Environmental Accessibility Adaptations	Event	20	1	$5,000.00	$100,000
Family Training	Hours	64	14	$41.41	$37,271
Habilitation Services	Hours	20	389	$31.29	$243,243
HCBSPC Benefit	Hours	1720	1941	$12.26	$40,924,676
Medical Equipment Operating Expense	Months	58	10	$25.00	$13,950
Personal Emergency Response Systems	Months	15	9	$32.14	$4,339
Personal Emergency Response Systems, Activation/Installation	Event	15	1	$35.70	$536
Private Duty Nursing	Hours	1660	2844	$30.85	$145,673,256
Respite – Facility	Days	22	5	$319.85	$35,183
Respite – Home	Hours	88	40	$24.09	$84,795
Transitional Case Management	Hours	38	20	$41.41	$31,390
Waiver Services Coordination	Hours	47	33	$41.41	$65,058
GRAND TOTAL:					**$190,525,737**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					2,755
FACTOR D (Divide grand total by number of participants)					**$69,156**
AVERAGE LENGTH OF STAY ON THE WAIVER					341

Waiver Year: 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Case Management	Hours	2915	26	$42.24	$3,228,633
Community Transition Services	Event	62	1	$5,000.00	$312,245
Environmental Accessibility Adaptations	Event	27	1	$5,000.00	$135,030
Family Training	Hours	66	14	$42.24	$39,064
Habilitation Services	Hours	20	389	$31.92	$253,355
HCBSPC Benefit	Hours	1836	1937	$12.51	$44,468,199
Medical Equipment Operating Expense	Months	112	9	$25.00	$26,083
Personal Emergency Response Systems	Months	15	9	$32.78	$4,444
Personal Emergency Response Systems, Activation/Installation	Event	15	1	$36.41	$548
Private Duty Nursing	Hours	1746	2805	$31.47	$154,089,104
Respite – Facility	Days	25	5	$326.24	$40,875
Respite – Home	Hours	97	40	$24.57	$95,657
Transitional Case Management	Hours	39	20	$42.24	$32,308
Waiver Services Coordination	Hours	49	33	$42.24	$69,338
GRAND TOTAL:					**$202,794,883**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					2,915
FACTOR D (Divide grand total by number of participants)					**$69,569**
AVERAGE LENGTH OF STAY ON THE WAIVER					341

Waiver Year: 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Case Management	Hours	3075	26	$43.09	$3,442,280
Community Transition Services	Event	67	1	$5,000.00	$333,005
Environmental Accessibility Adaptations	Event	29	1	$5,000.00	$142,810
Family Training	Hours	72	14	$43.09	$42,969
Habilitation Services	Hours	22	389	$32.56	$274,586
HCBSPC Benefit	Hours	1953	1933	$12.76	$48,170,901
Medical Equipment Operating Expense	Months	117	9	$25.00	$27,168
Personal Emergency Response Systems	Months	16	9	$33.44	$4,800
Personal Emergency Response Systems, Activation/Installation	Event	16	1	$37.14	$592
Private Duty Nursing	Hours	1832	2767	$32.10	$162,737,411
Respite – Facility	Days	27	5	$332.77	$44,097
Respite – Home	Hours	103	40	$25.06	$103,355
Transitional Case Management	Hours	41	19	$43.09	$34,562
Waiver Services Coordination	Hours	52	33	$43.09	$74,103
GRAND TOTAL:					**$215,432,640**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,075
FACTOR D (Divide grand total by number of participants)					**$70,059**
AVERAGE LENGTH OF STAY ON THE WAIVER					341

Waiver Year: 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Case Management	Hours	3235	26	$43.95	$3,663,181
Community Transition Services	Event	71	1	$5,000.00	$353,765
Environmental Accessibility Adaptations	Event	30	1	$5,000.00	$150,590
Family Training	Hours	76	14	$43.95	$45,426
Habilitation Services	Hours	23	389	$33.21	$296,565
HCBSPC Benefit	Hours	2071	1930	$13.01	$52,003,925
Medical Equipment Operating Expense	Months	122	9	$25.00	$28,254
Personal Emergency Response Systems	Months	17	9	$34.11	$5,169
Personal Emergency Response Systems, Activation/Installation	Event	17	1	$37.89	$638
Private Duty Nursing	Hours	1918	2733	$32.74	$171,670,015
Respite – Facility	Days	28	5	$339.42	$47,433
Respite – Home	Hours	109	40	$25.56	$111,323
Transitional Case Management	Hours	44	19	$43.95	$36,893
Waiver Services Coordination	Hours	54	33	$43.95	$79,031
GRAND TOTAL:					**$228,492,207**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,235
FACTOR D (Divide grand total by number of participants)					**$70,631**
AVERAGE LENGTH OF STAY ON THE WAIVER					341